

**Family Medicine Residency  
Program Manual  
2016-2017**

**Policies, Procedures, and Program Requirements for  
Residents and Participating Faculty**

The Morehouse Family Medicine Residency Program adheres to all policies and procedures of the Accreditation Council of Graduate Medical Education (ACGME), American Board of Family Medicine (ABFM), Morehouse School of Medicine (MSM), MSM Office of Graduate Medical Education (GME), the Department of Family Medicine (FM), and all participating sites and hospital affiliates. The policies written herein are in accordance with each of the aforementioned governing bodies. Residents are required to abide by these policies throughout their residency training. This policy manual supersedes any and all prior Family Medicine Policy Manuals.

Each resident is required to read this manual in its entirety and complete the acknowledgement of receipt stating that he/she has received, read, and fully understands the manual. This form will be placed in each resident's training file. The resident must seek clarification of program policies as needed prior to completing the acknowledgement form.

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## Preface

### **Morehouse School of Medicine (MSM) Vision and Mission**

#### MSM Vision

Leading the creation and advancement of health equity by:

- Translating discovery into health equity
- Building bridges between healthcare and health
- Preparing future health learners and leaders

#### MSM Mission

We exist to:

- Improve the health and wellbeing of individuals and communities;
- Increase the diversity of the health professional and scientific workforce;
- Address primary health care needs through programs in education research and service with emphasis on people of color and the underserved urban and rural populations in Georgia, the nation, and the world.

### **MSM Graduate Medical Education (GME) Goals and Objectives**

GME is an integral part of the Morehouse School of Medicine medical education continuum. Residency is an essential dimension of the transformation of the medical school graduate into the independent practitioner along the continuum of medical education. It is physically, emotionally, and intellectually demanding, and requires longitudinally-concentrated effort on the part of the resident.

Residency education at MSM has the following five goals and objectives for residents:

- To obtain the clinical knowledge, competencies, and skills required for the effective treatment and management of patients;
- To prepare for licensure and specialty certification;
- To obtain the skills to become fully active participants within the United States healthcare system;
- To provide teaching and mentoring of MSM medical students and residents;
- To directly support the school's mission of providing service and support to disadvantaged communities.

## **The MSM Family Medicine Residency Program**

### History

The MSM Family Medicine Residency Program is located in metropolitan Atlanta, Georgia, a city which is an economic and cultural center for not only the southeastern United States, but also the world at large.

Morehouse School of Medicine opened in September 1978 as part of Morehouse College, with Dr. Hugh Gloster as President and Dr. Louis Sullivan as Dean of the medical school. The Department of Family Medicine, the first clinical department, was established in July 1979. In 1981, the Department started the school's first residency program. The department has been an integral part of the development of the school and is a critical link in the school's educational programs. The residency program serves a significant role in Georgia as a producer of family physicians who practice among underserved populations with more than 60% of its graduates remaining in the state after training. The program is accredited by the Accreditation Council for Graduate Medical Education (ACGME).

Our program aims to be the best and most effective program in the southeast in developing superb family physicians for practice in underserved communities. We offer training in all aspects of family medicine including office procedures, community outreach, preventive medicine, and women's health care. In our 35-year history, we have successfully recruited well-qualified graduates of accredited medical schools. To date, there are a total of 156 graduates from our program, many of whom have received recognition at the state and national level for their outstanding contributions. A full complement of the brightest, most competent and compassionate students from around the nation and abroad join our residency training program.

The Morehouse Family Medicine Center, the Comprehensive Family Healthcare Center, is a model office that provides a setting that fosters educational excellence, provides research opportunities, and sets the pace for ambulatory office operations. Our faculty is a group of highly-trained, dedicated, and enthusiastic teachers who are effective in motivating their learners. They are involved in regular scholarly activities and are committed to maintaining excellence in education. Our faculty includes 19 physicians and four non-physician clinicians.

### Mission

The mission of the Morehouse School of Medicine's Family Medicine Residency is to:

- Train residents to become excellent family physicians who care for underserved populations;
- Provide training in behavioral medicine and family dynamics to foster the physician's awareness of the importance of the family unit in treating the patient;
- Provide physicians training experiences in both inpatient and outpatient care; and
- Provide residents with basic skills necessary to implement preventive care and to consistently educate patients about health and wellness.

Morehouse Family Medicine Residency is a community-based residency program that is affiliated with Atlanta Medical Center, Atlanta Veterans Affairs, Children's Healthcare of Atlanta, and Grady Memorial Hospital. The residency program director, Riba Kelsey-Harris, MD, is responsible for all resident-related policies and procedures. Overall residency program administration policy development is a shared responsibility of a leadership group including the director, associate director, and the members of the executive committee chaired by Dr. Folashade Omole (interim chair of the Department of Family Medicine). Key administrative and curricular components of the program are overseen by assigned faculty, clinical and administrative/support staff.

The business operation of the center is the responsibility of the senior department administrator, Mrs. Jamie Baker. The operation of the clinical area is the responsibility of the medical director, Michelle Nichols, MD. The Residency Program administrative staff oversees many of the administrative tasks related to residents.

### Setting

Hospital affiliates include:

- Grady Memorial Hospital (GMH)
- Children's Healthcare of Atlanta (CHOA)
- Atlanta Veteran's Affairs Hospital (VA)
- Atlanta Medical Center Main and South (AMC)

Residents in our program also obtain education from a number of physicians in the private and public sectors for outpatient rotations.

### Administration Duties and Responsibilities

#### *Program Director – Dr. Riba Kelsey-Harris*

The program director provides the overall leadership, development, and implementation of the residency program. The program director ensures that the program is compliant with all Accreditation Council for Graduate Medical Education (ACGME) requirements for a family medicine residency training program. The program director is responsible for residents' progression and matriculation from the program and for the information that is communicated to residents, mainly via semi-annual resident evaluations. The program director tracks and reviews all resident evaluations, procedure and patient logs, and duty hours to ensure overall resident and program compliance.

Other responsibilities include:

- Oversight of all aspects of the residency program and resident education

- Creating and maintaining the affiliation agreements and alliances with the necessary educational and clinical entities, hospitals, clinics, and individual physicians to provide the highest quality training opportunities in the field of family medicine
- Updating and modifying educational goals and curricula
- Overseeing and approving topics for lectures and instruction as deemed fit by the program and the emerging guidelines of the Residency Review Committee (RRC) and the American Board of Family Medicine
- Directly supervising the program manager, the core family medicine faculty, and staff involved with the residency program implementation
- Working closely with the department's chairperson and other officials at MSM to ensure that the program reflects the mission of the institution as well as the department
- Overseeing the resident selection and promotion process

*Associate Program Director – Dr. Folashade Omole*

The associate program director assists the program director in developing and implementing the program while completing specific assigned tasks. These tasks include developing and modifying the family medicine residency curriculum, conducting semi-annual evaluations with residents, overseeing the program operations, and assisting with didactic teaching and conference schedules. The associate program director also represents the program at official meetings within the institution and outside, as needed, in the absence of the program director.

*Assistant Program Director (presently unfilled)*

The assistant program director assists the residency program director and associate program director in program operations. The assistant program director schedules and conducts resident educational conferences such as Grand Rounds, Morning Report and mock code, and weekly didactic lectures. The assistant program director assists with the resident selection process, maintains the evaluation system for residents and preceptors, and oversees the chief residents in development and maintenance of the resident master schedule.

*Chief Resident*

The chief resident(s) supports resident teaching activities such as Grand Rounds, Morning Report, and weekly didactics. The chief resident supervises the development and modification of resident schedules, reviews vacation requests for feasibility, and arranges back-up coverage for unplanned absences. The chief resident attends faculty meetings of the department and serves as the resident liaison. The chief resident is appointed from the rising graduating class by April of the academic year. The appointed chief(s) must be in good standing for the most recent 18 months at the time of chief resident selection.

*Program Manager – Colleen Stevens, MBA*

The program manager manages the daily operational activities of the residency program and interacts with personnel at affiliated institutions, as needed. The program manager ensures that the residents complete all required paperwork, including obtaining completed evaluations. The program manager also ensures that residents' master files, evaluations, immunization certificates, visa documents, United States Medical Licensing Examination (USMLE) scores, and procedure and patient logs are kept up to date. The program manager is responsible for completing and filing all required paperwork and communications from internal and external entities (e.g., MSM Graduate Medical Examination [GME] office, American Board of Family Medicine, American Academy of Family Physicians). The program manager coordinates the resident recruitment activities in conjunction with the program director.

*Program Assistant – Angel Allen*

The program assistant provides administrative support to the program director, associate program director and program manager. The program assistant provides professional and prompt completion of data entry, expense requests, travel support, program documentation and meeting logistics.

*Resident Advisors*

Each resident is assigned to a family medicine faculty advisor for the duration of his or her training. The advisor's role is to monitor the resident's progress in training and provide guidance in his or her clinical and scholarly pursuits throughout residency.

Residents are strongly encouraged to initiate and maintain contact with their advisors from the time of orientation and throughout the duration of their residency training. Advisors are expected to document meetings with their resident advisee. Topics discussed should be noted and the entire report should be forwarded to the program director's office for placement in the resident's file. Residents should meet with their resident advisors at least once every three months.

The resident advisor should assist the resident with adapting a study plan for the three years of residency. The resident advisor will also review the resident's Individual Education Plan (IEP), give feedback on adjustments, and monitor the resident's progress on goals. The resident advisor should discuss the resident's performance on rotations, review his or her rotation evaluations, and provide strategies for improving weaknesses.

The resident advisor should also review the resident's in-training exams and guide the resident's study plan. The resident advisor also represents the resident in cases of due process and provides information about career paths. The resident advisor should also monitor the resident's quality improvement and research projects.



## Training Goals

The MSM Family Medicine Residency Program goals are listed below:

- Provide the Family Practice resident with the knowledge, skills, and attitudes to competently manage medical patients with simple and complex problems.
- Provide a foundation which can be expanded and refined during medical subspecialty rotations.
- Provide the resident with knowledge about how family dynamics and behavioral medicine principles apply to the hospitalized medical patient.
- Teach the resident to utilize the concept of the “healthcare team” whereby the physician is the coordinator of the health team’s efforts, calling upon support and input from personnel in nursing, social work specialty clinics, nutrition, administration, and chaplain staff.
- Teach the resident to recognize the limits of one’s own knowledge and skills and institute timely and appropriate consultation.
- Teach the resident to exhibit patterns of inter-professional collaboration and cooperation which enhance patient care.
- Teach the resident to recognize that hospital care is merely one phase on a continuum of longitudinal and continuous medical care.
- Train family physicians to provide comprehensive, continuing care to all of their patients.
- Stimulate the analytical attitude toward the most efficient and effective use of the physician’s time, personnel, and facilities in order to provide optimal care to patients.
- Implement preventive services and consistently educate patients about health.
- Train Family Medicine residents in the six core competencies, as identified by the ACGME:
  - Patient care
  - Medical knowledge
  - Practice-based learning and improvement
  - Interpersonal and communication skills
  - Professionalism
  - Systems-based practice

## Program Elements

### *Morning Report*

- Morning Report occurs Fridays at 8:00 a.m. at Atlanta Medical Center South.
- Residents on the inpatient service and all residents assigned to the CFHC are required to attend.
- Night float residents are required to attend Morning Report post-shift.

### *Conferences/Didactic Sessions*

- Residency didactic sessions are held each Wednesday, 12:30 p.m.–5:00 p.m., unless otherwise notified of any changes. These conferences are a required component of residency training as described in the [ACGME Program Requirements for Graduate Medical Education in Family Medicine](http://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/120_family_medicine_2016.pdf) (IV.A.3.), which can be accessed at the following link: [http://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/120\\_family\\_medicine\\_2016.pdf](http://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/120_family_medicine_2016.pdf)

### *Clinical Rotations*

- ACGME-required and carefully selected program-required clinical rotations are essential to the development of the clinical and interpersonal skills necessary for future independent practice. The required clinical rotation experiences are described in section IV.A.6.b-k of the [ACGME Program Requirements for Graduate Medical Education in Family Medicine](#).

### *Continuity Clinic*

- Central to the training of a Family Physician is the establishment of a panel of continuity patients in the ambulatory setting. As such, each resident sees patients in the Morehouse Healthcare Comprehensive Family Healthcare Center, our established Family Medicine Practice (FMP) site, throughout all three program years. Required visit numbers and types of patients are detailed in section IV.A.6.a).(5) of the [ACGME Program Requirements for Graduate Medical Education in Family Medicine](#)

### *Scholarly Activity*

- The program provides a longitudinal research curriculum that prepares residents to produce quality scholarly activity.
- Residents are required to complete a PSQI “mini-project” during their Practice Management rotation and a larger research project in fulfillment of their PGY3 research requirement.
- Aside from meeting these requirements, the program encourages scholarly activity in the form of letters to the editor, case reports, conference presentations, non-required PSQI projects, and the like to foster a sense of inquiry and establish the habit of contributing to the body of knowledge in our discipline.

## Benefits

### *Continuing Medical Education (CME)/Book Allowance*

Each year, all PGY-2 and PGY-3 residents receive CME funds for educational purposes. Due to a vigorous schedule, first year residents are not granted continued education conference time. However, first year residents receive technological equipment purchased by the department. Second and third year residents may take up to five educational days for travel to present scholarly work and research. CME funds are allocated according to the following schedule:

PGY-1	Laptop provided by the department
PGY-2	AAFP Board Review Course
PGY-3	\$750.00

Additionally, up to \$1,000 of the ABFM exam registration fee is reimbursed upon taking the exam by the 34<sup>th</sup> month of training and passing on the first attempt pending availability of funds.

Examples of items that can be purchased with CME funds are medical books related to Family Medicine only, stethoscopes, scrubs, medical software for handheld devices, and CME conferences.

CME funds cannot be used for computers, computer equipment, or personal device accessories. The residency office should be consulted prior to purchase in cases of uncertainty about eligibility for CME funds.

All CME funds must be used in the current fiscal year, no later than April 15th. **CME funds do not rollover.**

### *Professional Organizations*

The program provides residents membership in the American Academy of Family Physicians (AAFP) and Georgia Academy of Family Physicians.

### *Pagers*

The department provides pagers to residents at no charge. However, there is a \$50.00 charge to replace lost or stolen pagers, which is the responsibility of the resident. If a pager is lost or stolen, the resident must notify residency administrative personnel immediately to arrange for replacement.

Morehouse School of Medicine also uses the Spok paging system, which allows pages to be received directly on each resident's smart phone. Enrollment in the Spok paging system will occur during new resident orientation. Prompt response to pages and text messages while on duty is mandatory and is part of the Professionalism competency.

### *Vacation/Sick/CME Leave*

Each resident is receives up to 15 days of vacation, 15 days of sick leave, 10 days of administrative leave, 5 days of educational (CME) leave, and holiday leave depending on the current rotation at the time of a recognized holiday. Specific policies related to each type of leave are detailed in the Benefit Time section of this document.

## **Policies and Procedures**

### **GME Adverse Action and Due Process Policy**

Our goal is to assist residents to avoid situations requiring adverse academic decisions and actions. However, when situations requiring adverse action occur, the program follows the GME Adverse Academic Decisions and Due Process Policy and related MSM Human Resource policies as documented in the GME Policies link at <http://www.msm.edu/Education/GME/index.php>.

### **Program Concern/Complaint Policy**

The Program Concern/Complaint Policy ensures that residents can raise concerns and complaints pertaining to personnel, patient care, the program, or hospital training environment matters and to provide feedback without intimidation or retaliation. The policy includes a mechanism for communicating concerns and complaints confidentially, as appropriate. The process and resources available for reporting concerns and complaints are detailed below. This process is reviewed annually with residents and faculty.

#### Step 1

Discuss the concern or complaint with the chief resident, clinical service director, program manager, associate program director and/or program director as appropriate.

#### Step 2

If the concern or complaint involves the Program Director and/or cannot be addressed in Step 1, residents have the option of discussing issues with the Interim Department Chair, Dr. Folashade Omole at [fomole@msm.edu](mailto:fomole@msm.edu) or (404) 756-1206 or the service chief of a specific hospital as appropriate.

#### Step 3

If the resident is not able to resolve the concern or complaint within the Program or Department, the following resources are available:

- For issues involving program concerns, training matters, or the work environment, residents can contact the Graduate Medical Education Director, Tammy Samuels at [tsamuels@msm.edu](mailto:tsamuels@msm.edu) or (404) 752-1011

- For problems involving interpersonal issues, the Resident Association President or President-Elect is available to discuss confidential informal issues that arise outside of the Department of Family Medicine (issues within the Department should first be discussed with one of the Family Medicine Chief Residents if comfortable)
- Anonymous feedback/concerns/complaints can be provided at any time by completing the online GME Feedback form available at the following website:  
<http://fs10.formsite.com/bbanks/form33/index.html>.

Comments made on this site are anonymous and cannot be traced back to an individual. However, a resident may elect to provide his/her name and contact information if he/she desires personal follow-up regarding how feedback/concerns/complaints have been addressed by the Departments and/or the GME office.

- For issues involving compliance, the MSM Compliance Hotline at (855) 279-7520 and [on-line reporting portal](https://secure.ethicspoint.com/domain/media/en/gui/44523/index.html) at <https://secure.ethicspoint.com/domain/media/en/gui/44523/index.html> are available. These are anonymous and confidential mechanisms for reporting unethical, noncompliant, and/or illegal activity and should be used to report any concern that could threaten or create a loss to the MSM community, including the following:
  - Harassment- sexual, racial, disability, religious, retaliation
  - Environmental Health and Safety- biological, laboratory, radiation, laser, occupational chemical, and waste management and safety issues
  - Other- misuse of resources, time, or property assets; accounting, audit and internal control matters; falsification of records; theft, bribes, and kickbacks

## GME Duty Hour Policy

The Family Medicine Residency Program strictly follows the Duty Hour Rules as mandated by the ACGME and in keeping with the GME Duty Hour Policy as documented in the GME Policy Manual at <http://www.msm.edu/Education/GME/index.php>.

### Duty Hour Rules

Duty hours are defined as time spent on **all clinical and academic activities related to the residency program**, such as patient care (both in-patient and out-patient), administrative duties related to patient care, the provision for transfer of patient care, in-house call activities, and scheduled academic conferences/didactics. Hours spent moonlighting must also be included in the duty hour calculation. Duty hours **do not** include reading and academic preparation time spent away from the duty site.

The ACGME considers duty hour limits to be an important element of its comprehensive approach to promote high quality education, wellness, and safe patient care. Residents must adhere to all duty hour requirements as detailed below:

- Duty hours are limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house activities.
- Residents must have (1) day in seven (7) free from all educational and clinical responsibilities, averaged over a four-week period, inclusive of call. "One day" is defined as one continuous 24-hour period.
- Adequate time for rest and personal activities is required. Residents should have at least 10 hours and must have at least 8 hours free between all daily duty periods and in-house call assignments
- In-house call must occur no more frequently than every third night, averaged over a four-week period
- Duty periods of PGY-1 residents must not exceed 16 hours in duration.
- Duty periods of PGY-2 residents and above may be scheduled to a maximum of 24 hours of continuous duty. As effective transitions of care are essential for patient safety and resident education, residents may remain on-site to accomplish this for a period not to exceed an additional four hours. The resident must not be assigned additional clinical responsibilities after 24 hours of continuous in-house duty.

### **Program Duty Hour Monitoring and Reporting Process**

Reporting of resident duty hours is required by the residency accrediting agency, the ACGME/Residency Review Committee, and therefore, are not optional. Daily duty hour logging in [New Innovations](#) is expected and logging within 5 days is required.

The following guidelines apply to logging duties:

- Logging should be continuous with no gaps (for example for lunch or travel between clinical sites).
- Conferences should be logged contiguous with other duties with no gaps in between.
- For in-house call, log duty type "Call". For back-up call assignments when the resident has to go into the hospital, log duty type "Back Up- Called In". **NOTE:** Back-up residents do not log if they do not go into the hospital.
- If your 24-hour shift is extended duty to post-call transitions of patient care or mandatory conferences, avoid a violation by logging the following two duty types (1) post-call and (2) conferences for the hours that extend beyond the 24-hour period.
- Log appropriate duty types for moonlighting, vacation, holiday/day off, or sick days.
- Each resident must enter written justification or cause in the event of a violation.
  - Justifications apply to violations of 24+ or short break rule.
  - Causes apply to any violation.
  - These must be submitted to the program director

Duty hour logging is monitored by the Program Manager who provides a weekly logging status report to the Program Director. In the absence of a report, a review of the New Innovations Dashboard is performed weekly to assess compliance with duty hour logging and to determine if any duty hour violations have occurred since the last review. If a resident has not logged in one week or more, he/she will receive a notification from the Program Manager to encourage immediate logging. If duty hours are not logged after notification from the PM, the Program Director will contact the resident and a written explanation of why the duty hours have not been logged must be submitted by the resident and placed in his/her file. Repeated or prolonged duty hour logging delinquency may result in disciplinary action as appropriate for deficiency in the Professionalism competency

In the event that a duty hour violation occurs, the resident's log is immediately flagged at which time the resident must provide a justification or explanation for the violation in New Innovations. Duty hour violations are monitored and recorded in New Innovations and are automatically reported to the Program Director, Associate Program Director, and Program Manager electronically. The Program Director must then review the violation and the resident's explanation of the causal circumstances to determine whether or not the violation was justified. In the case of an unjustifiable violation, the Program Director must provide education to the resident, faculty member, and service involved to avoid future violations.

This procedure will allow the Program Director and/or the Program Manager to both provide necessary education to individual residents and to determine if there are systemic scheduling patterns that must be adjusted. In the short term, however, duty hour restrictions should not serve as a reason to jeopardize patient safety.

### **Alertness Management & Fatigue Mitigation Information**

Annually, residents and faculty are provided with education on identifying and mitigating fatigue. Fatigue in a resident can be identified either by the resident him- or herself, a fellow resident, or a faculty member. In either case, when recognized, the resident may be offered time for rest, especially if he/she has been on duty for more than 16 hours continuously. In this case, appropriate patient handoff must occur before respite time begins. In the case of fatigue or anticipated fatigue due to unexpected duty as in the case of labor and delivery management of a continuity patient prior to a call, a resident may discuss this with his/her chief resident(s) to develop a solution which may include a call switch or coverage of a portion of a call by another resident as long as this does not cause a duty hour violation for the covering resident. Additionally, when creating the night float, call, and clinic schedules, the chief residents also assign a backup resident who is available for coverage in these situations or to come in to assist a resident on in-hospital duty who is overwhelmed with an unexpected increase in patient volume or acuity.

A "Safe Ride Home" policy addresses the situation in which a resident is excessively fatigued upon completion of his/her duty. The policy is detailed below.

#### *Safe Ride Home Policy*

##### Purpose

To outline a process whereby residents who feel too fatigued to safely drive home after a rotation day can feel encouraged to call a cab for a safe ride home from rotation and back again to retrieve their vehicle

or report for duty the next day and be reimbursed for the expense. The resident may in the absence of the ability to return to the original location to pick up his or her vehicle after appropriate rest obtain a cab ride back to the original destination and submit that receipt for reimbursement.

### Process

If a situation arises in which a resident is unable to safely drive home at the end of his/her shift due to extreme fatigue or the late hour, the resident is encouraged to take a nap prior to driving home if possible given the physical location and access to a secure location for sleeping. In the absence of sleeping as an option, the resident should contact a local taxi company for a safe ride home. The resident should keep the receipt from the ride and bring it to the program office within 30 days of the ride for reimbursement of 100% of the fare (tip not included). The receipt must be accompanied by a description of the circumstances that caused the fatigue and required the use of the safe drive home. All current MSM reimbursement policies apply.

### Responsibility

The program offers this service as a way to encourage a resident who is too fatigued to safely drive home to obtain a cab ride home by offering to reimburse the resident for cost of cab fare plus tip per MSM guidelines. The resident holds the responsibility in knowing when he or she needs to utilize this service. The system is not to be abused and must be utilized when absolutely necessary.

### **Program Call Policy/Guidelines**

#### Night Float/Call Responsibilities

(5:00 p.m. to 7:00 a.m.)

PGY2 and PGY3 residents are assigned to the night float schedule by the Chief Resident(s). Night float assignments are based on resident availability and current rotation assignments. Residents are not eligible for night float during the following rotation: FM Wards, ECC, Urology/Radiology, ENT/Ophthalmology, and Peds at GEP during any month during which the attending has vacation. Additionally, night float assignment during the same month that a resident has a vacation is avoided although it may occur in rare instances if there are no other residents available. Although every effort is made to ensure equitable assignment of night float weeks, the situation occasionally arises when one resident may have more night float sessions than another. In all cases, duty hour rules are followed.

During the week of night float, the assigned resident will cover the Family Medicine Inpatient Service at AMC-South from 5:00pm to 7:00am from Sunday to and including Friday. The resident shall not report to his/her assigned rotation during the night float week.

During the night float shift, the night float resident assumes responsibility for the care of the patients carried by the inpatient team at the time of sign out including but not limited to ordering and reviewing lab tests and studies, reviewing notes from consultants, evaluating patients, as needed, responding to calls from nurses and the answering service, and admitting patients to the Morehouse Family Medicine



and hospitalist services in accordance with established patient cap agreements. After performing the history and physical, the resident must call the attending on call to discuss the history, physical, assessment, and proposed management for approval in order to finalize the admission orders. Direct admissions are discouraged in the interest of patient safety. However, if an attending proposes to admit a patient directly, he/she must first discuss the patient with the inpatient attending to determine whether initial evaluation and management in the emergency department is more appropriate.

The resident will spend the remaining three (3) to three and a half (3.5) weeks with his or her duties divided between his or her rotation and the family medicine continuity clinic.

### Long Call and Short Call

Residents on VA rotations who are not assigned to night float during a given month are eligible to be assigned to one long call and one short call during that month. Long call is defined as a 24 hour call at AMC-South from 7:00 am Saturday morning to 7:00 am Sunday morning. Short call is described as a 12-hour shift on Sunday from 7:00am to 7:00pm. The responsibilities of the long call and short call resident are the same as the resident responsibilities described in the Night Float section above.

In addition to the aforementioned responsibilities, the night float, short call, and long call residents are responsible for receiving, addressing, and documenting all after-hours phone calls from the FMP. The resident will contact the FMIS attending if he or she needs any assistance or has any questions. All phone calls must be documented in the office Electronic Health Record and the patient's primary care provider should be copied on the documentation of the conversation.

### **Unusual Resident-Initiated Extensions – Additional Duty**

Residents must not be assigned additional clinical responsibilities after 24 hour of continuous in-house duty. However, in unusual circumstances, a resident on his/her own initiative may remain at the clinical site beyond the 24 hour period to provide care to a single patient. In these cases, the following justification for extending duty must meet one of the following conditions:

- provision of continuity of care for a severely ill, complex, or unstable patient
- provision of continuity for a maternity care continuity delivery patient with whom the resident has been involved
- the transpiring events must have significant educational value
- provision of humanistic attention to the needs of a patient or family

In each circumstance, the following actions must be taken:

- The resident must appropriately hand over the care of all other patient to the team responsible for their continuing care
- The resident must document the reasons for remaining to care for the patient in New Innovations
- The Program Director must review each submission of additional service and track both individual resident and program-wide episodes of additional duty.

This program policy is consistent with Morehouse School of Medicine GME policies 7.2.2 and 7.2.3

### **Senior resident – Preparation to Enter Unsupervised Practice of Medicine**

Consistent with the MSM GME Policy and the ACGME Program Requirement VI.G.5.c, residents in the final year (PGY-3) of education must be prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended periods.

Per the ACGME Policy, this preparation must occur within the context of the following duty hour rules: 80-hour work week, maximum duty period length, and one-day-off-in seven. However, while it is desirable that PGY-3 residents have eight hours free of duty between scheduled duty periods, there may be circumstances when these residents must stay on duty to care for their patients or return to the hospital with fewer than eight hours free of duty. As defined by the Residency Review Committee in section VI.G.5.c.(1).(b), these circumstances are those which require continuity of care for a severely ill or unstable patient, a complex patient, a maternity care continuity delivery patient with whom the resident has been involved; events of exceptional educational value; or humanistic attention to the needs of a patient or family. These circumstances must be monitored by the Program Director.

## **GME Eligibility and Selection Policy**

The Morehouse School of Medicine Eligibility and Selection process is consistent with the MSM GME Eligibility, Selection, and Appointment Policy as documented in the GME Policy Manual at <http://www.msm.edu/Education/GME/index.php>.

### **Program specific process and criteria**

Morehouse School of Medicine Family Medicine participates in the Electronic Residency Application Service (ERAS) and only accepts applications through this system. The deadline to apply is December 31<sup>st</sup>. ERAS may be contacted at (202) 828-0413. United States graduates, even if not a current student, should apply using their medical school's Dean's office to obtain access to ERAS and to upload documents designated for upload by the institution. International graduates should apply through the Educational Commission for Foreign Medical Graduates (ECFMG).

Applicants must either attend or be a graduate of a LCME school or a school recognized by the State of California Medical Licensure Board to be ranked by the Program. A list of these schools is available at the [Medical Board of California website](#). Additionally, applicants must have passed USMLE Step I, Step II Medical Knowledge, and Step II Clinical Skills Exam in order to be considered for our Match Ranking List. Preference for ranking is placed on applicants with a minimum passing score of 215 on Step 1 and 230 on Step 2. Further, the applicant must have United States citizenship, permanent residency, or J-1 visa status in order to enter the program. The program does not admit anyone with any other type of visa and does not sponsor visas. International medical graduates must have a valid ECFMG certificate with a date no later than March 20<sup>th</sup> and must possess a social security card with no restrictions.

Our program requires that all applicants have at least six (6) months of clinical experience in the United States or Canada that does not include observership or research. We must have documentation of this from a faculty member of a LCME-accredited medical school for American graduates and from the host hospital for international graduates.

ERAS applications will be considered noncompetitive if the applicant has not passed either USMLE on the second attempt and Clinical Skills Exam on first attempt. It is preferred that applicants who have already graduated medical school have taken and passed USMLE Step III.

The final rank list is determined by information in the ERAS application, applicant interview, and supplemental sources, and by input from residents, faculty, and staff who participated in any part of the recruitment and/or interview process.

Questions regarding the program's criteria must be directed to the Program Manager at (800) 724-1025.

## **Program Evaluation Policies & Processes**

### **GME Evaluation and Promotion Policy**

The MSM Family Medicine Residency Promotion Policy is consistent with the MSM Graduate Medical Education Promotion Policy which can be accessed on the GME Policies link on the Office of Graduate Medical Education link. <http://www.msm.edu/Education/GME/index.php>

### **Resident Performance Evaluation**

The ACGME requires that faculty evaluate residents on their performance in a timely manner during their rotations and other educational assignments, and must be documented at the completion of the assignment. The Program assures that all residents are systematically evaluated on their knowledge, skills, performance, and professional growth on an ongoing basis throughout their training. The Program collects this information through multiple sources including rotation and clinic evaluations, advisor input, ITE performance, resident logs, and other pertinent sources as described below. Each form of evaluation is designed to assess the resident using the 6 core competencies of Patient Care, Medical Knowledge, Systems Based Practice, Problem Based Learning, Professionalism, and Interpersonal Skills and Communication and assesses progression along the ACGME required Milestones. While on clinical rotations all residents receive written and/ or verbal formative evaluations and written and verbal summative evaluation. Residents also receive feedback on their performance globally through semi-annual evaluations which provide formative evaluation throughout the course of residency training and a summative evaluation at the end of training. All information is compiled in New Innovations.

Forms of Formal Evaluation:

- Direct observation during continuity clinic and inpatient encounters and during OSCE
- Peer to Peer and Staff to Resident (360)

- Patient Satisfaction Surveys
- Faculty Evaluation of Residents on clinical rotations
- Faculty Evaluation of Resident Clinical Performance
- Self-assessment
- Semi-annual evaluation using tools listed above, ITE performance, and resident log data
- Summative (final evaluation of performance prior to completion of training)

Semi-annual evaluations are conducted by the PD and/or APD with each resident and are required by the ACGME. These are formal sessions in which feedback is provided to the resident regarding his/her overall performance from July to December and from January to June. During the Semi-annual evaluation, the resident must also be prepared to discuss his/her self-evaluation and individualized education plan. The Semi-annual evaluation session also provides an opportunity for resident to provide feedback to the program.

### **Clinical Competency Committee (CCC)**

The CCC for the Morehouse School of Medicine Family Medicine Residency Program is charged with monitoring resident performance and making appropriate recommendations to the Program Director regarding each resident's progression and promotion based on a review of multiple forms of resident evaluations, In-Training Examination performance, and logging documentation. At all times the policies and procedures of the CCC will comply with those of the Morehouse School of Medicine Office of Graduate Medical Education (GME) regarding promotion and dismissal. The full CCC Policies and Responsibilities document can be found in the Appendix section of this document.

### **PGY-Specific Performance Expectations**

The following list includes tasks that are representative of those required of a resident in family medicine at Morehouse School of Medicine. The list is not meant to be all-inclusive nor does it constitute all academic performance measures or graduation standards. It does not preclude the residency from temporarily restructuring resident duties, as it deems appropriate for residents with acute illness, injury, or other circumstances of a temporary nature.

#### PGY-1 Level

##### Prerequisites

- Medical doctorate from an allopathic or osteopathic medical school
- Passing scores on the USMLE I, USMLE II CK, and USMLE II CS

- Foreign medical graduates: complete all ECFMG requirements
- Eligibility for State of Georgia Family Physician training licensure
- Application through Electronic Resident Application System (ERAS)

### Qualities

- Possess the attitudes, knowledge, and skills needed for learning the broad spectrum of family medicine.
- Demonstrate effective interpersonal skills with a diverse population that includes patients, medical staff, faculty, other residents, nursing staff, and medical office personnel.
- Work within multiple teams that include inpatient rounding teams, class peers, curriculum development teams, outpatient care teams, and support groups.
- Communicate effectively in English both verbally and in writing.

### Management of Physical and Mental Demands, Environment, and Working Conditions

- Work using sterile technique, universal body secretion precautions, and respiratory isolation equipment.
- Move around the hospital and its campus adequately to address routine and emergency patient care needs.
- Use diagnostic equipment essential to family medicine including the ophthalmoscope, stethoscope, and ultrasound.
- Read patient charts and monitoring equipment.
- Manage multiple patient care duties simultaneously.
- Use judgement and make decisions regarding complicated and undifferentiated disease presentations that are timely and appropriate for the situation in ambulatory, emergency, and hospital settings.
- Have the capacity to see five (5) or more outpatient cases in a three-hour clinic session, four (4) or more hospital admissions in a 12-hour period, and have the ability to complete appropriate documentation in a timely fashion.
- Work shifts up to 16 hours on inpatient services.
- Use computers for literature review, patient care data retrieval, and procedure documentation.
- Communicate complex medical information rapidly and effectively with other members of a health care team.

### Performance Responsibilities and Job Functions

### *Outpatient Care*

- Provide longitudinal primary medical care to a panel of outpatients.
- Learn to perform procedures essential to family medicine including male infant circumcision, endometrial biopsy, colposcopy, IUD insertion and removal, and OB ultrasound.
- Work effectively within a patient-care team.
- Complete clinic notes, procedure notes, referral requests, L&D evaluations, and other required documentation in a timely fashion.
- Work effectively with medical staff on specialty outpatient rotations.

### *Inpatient Care*

- Perform complete H&Ps on new hospital admissions and patients presenting for emergency evaluation.
- Perform CPR on infants and adults as indicated.
- Manage laboring women, perform deliveries, and repair obstetric trauma under the supervision of a family physician or obstetric attending.
- Administer injections, take blood samples, and learn to insert arterial and central lines.
- Write and dictate admission and discharge notes, progress notes, delivery notes, and other necessary hospital documentation.
- As necessary, write orders for physical and chemical restraints and seclusion.

### *Educational Mission*

- Present educational material in formats appropriate adjusted for the audience (i.e. medical students, peers, medical staff, or community groups)
- Complete and pass all required rotations.
- Provide feedback to the program both spontaneously and when requested.
- Perform an academic self-assessment at least twice per year.
- Participate in curriculum development through the work of standing committees.
- Develop continuing quality improvement projects in conjunction with residency and faculty.

### *PGY-2 Level*

### *Prerequisites*

- Completed and passed all rotations and requirements of a PGY-1
- Has met the minimum competency skills needed to teach students and peers

### Qualities

- Possess the attitudes, knowledge, and skills needed for learning the broad spectrum of family medicine.
- Demonstrate effective interpersonal skills with a diverse population that includes patients, medical staff, faculty, other residents, nursing staff, and medical office personnel.
- Work within multiple teams that include inpatient rounding teams, class peers, curriculum, development teams, outpatient care teams, and support groups.

### Management of Physical and Mental Demands, Environment, and Working Conditions

- Work using sterile technique, universal body secretion precautions, and respiratory isolation equipment.
- Move around the hospital and its campus adequately to address routine and emergency patient care needs.
- Use diagnostic equipment essential to family medicine including the ophthalmoscope, stethoscope, and ultrasound.
- Read patient charts and monitoring equipment.
- Manage multiple patient care duties simultaneously.
- Use judgment and make decisions regarding complicated and undifferentiated disease presentations that are timely and appropriate for the situation in ambulatory, emergency, and hospital settings.
- Have the capacity to see 10 or more outpatient cases in a three-hour clinic session, 12 or more hospital admissions in a 24-hour period, and have the ability to complete appropriate documentation in a timely fashion.
- Work shifts up to 24 hours when taking call on the inpatient services.
- Use computers for literature review, patient care data retrieval, and procedure documentation.
- Communicate complex medical information rapidly and effectively with other members of a healthcare team.

### *Performance Responsibilities and Job Functions*

#### Outpatient Care

- Provide longitudinal primary medical care to a panel of outpatients.

- Provide longitudinal primary medical care to a panel of nursing home patients.
- Learn to perform procedures essential to family medicine including male infant circumcision, colposcopy, IUD placement and removal, endometrial biopsy, and OB ultrasound.
- Work effectively within a patient-care team.
- Complete clinic notes, procedure notes, referral requests, L&D evaluations, and other required documentation in a timely fashion.
- Work effectively with medical staff on specialty outpatient rotations.

### Inpatient Care

- Manage the care of ward and critical care patients under the supervision of a family physician or medical attending.
- Perform complete H&Ps on new hospital admissions and patients presenting for emergency evaluation.
- Run the code team (second and third year of program).
- Perform CPR on infants and adults as indicated.
- Intubate infants, children, and adults as indicated.
- Manage laboring women, perform deliveries, and repair obstetric trauma under the supervision of a family physician or obstetric attending.
- Independently manage precipitous deliveries.
- Assist with major surgeries and C-sections.
- Administer injections, take blood samples, and learn to insert arterial and central lines.
- Write or dictate admission and discharge notes, progress notes, delivery notes, and other necessary hospital documentation.
- As necessary, write orders for physical and chemical restraints and seclusion.

### Educational Mission

- Present educational material in formats appropriate adjusted for the audience (i.e. medical students, peers, medical staff, or community groups)
- Supervise the hospital care provided by R-1.
- Complete and pass all required rotations.



- Provide feedback to the program both spontaneously and when requested.
- Perform an academic self-assessment at least twice per year.
- Participate in curriculum development through the work of standing committees.
- Develop continuing quality improvement projects in conjunction with residency and faculty.

### PGY-3 Level

#### Prerequisites

- Completed and passed all rotations and requirements of a PGY-2
- Taken and passed USLME III
- Has met the minimum competency skills needed to teach students and peers

#### Qualities

- Possess the attitudes, knowledge, and skills needed for learning the broad spectrum of family medicine.
- Demonstrate effective interpersonal skills with a diverse population that includes patients, medical staff, faculty, other residents, nursing staff, and medical office personnel.
- Work within multiple teams that include inpatient-rounding teams, class peers, curriculum, development teams, outpatient care teams, and support groups.

#### Management of Physical and Mental Demands, Environment, and Working Conditions

- Work using sterile technique, universal body secretion precautions, and respiratory isolation equipment.
- Move around the hospital and its campus adequately to address routine and emergency patient care needs.
- Use diagnostic equipment essential to family medicine including the ophthalmoscope, stethoscope, and ultrasound.
- Read patient charts and monitoring equipment.
- Manage multiple patient care duties simultaneously.
- Use judgment and make decisions regarding complicated and undifferentiated disease presentations that are timely and appropriate for the situation in ambulatory, emergency, and hospital settings.

- Have the capacity to see 10 or more outpatient cases in a three-hour clinic session, 12 or more hospital admissions in a 24-hour period, and have the ability to complete appropriate documentation in a timely fashion.
- Work shifts up to 24 hours when taking call on the inpatient services.
- Use computers for literature review, patient care data retrieval, and procedure documentation.
- Communicate complex medical information rapidly and effectively with other members of a healthcare team.

Performance Responsibilities and Job Functions

*Outpatient Care*

- Provide longitudinal primary medical care to a panel of outpatients.
- Provide longitudinal primary medical care to a panel of nursing home patients.
- Learn to perform procedures essential to family medicine including male infant circumcision, endometrial biopsy, IUD insertion and removal, colposcopy, and OB ultrasound.
- Work effectively within a patient-care team.
- Complete clinic notes, procedure notes, referral requests, L&D evaluations, and other required documentation in a timely fashion.
- Work effectively with medical staff on specialty outpatient rotations.
- Serve as a team leader for two (2) months during senior year.

*Inpatient Care*

- Manage the care of ward and critical care patients under the supervision of a family physician or medical Attending.
- Perform complete H&Ps on new hospital admissions and patients presenting for emergency evaluation.
- Run the code team (second and third year of program).
- Perform CPR on infants and adults as indicated.
- Intubate infants, children, and adults as indicated.
- Manage laboring women, perform deliveries, and repair obstetric trauma under the supervision of a family physician or obstetric Attending.
- Independently manage precipitous deliveries.

- Assist with major surgeries and C-sections.
- Administer injections, take blood samples, and learn to insert arterial and central lines.
- Write or dictate admission and discharge notes, progress notes, delivery notes, and other necessary hospital documentation.
- As necessary write orders for physical and chemical restraints and seclusion.

### Educational Mission

- Present educational material in formats appropriate adjusted for the audience (i.e. medical students, peers, medical staff, or community groups)
- Supervise the hospital care provided by R-1, R-2, and medical student.
- Complete and pass all required rotations.
- Provide feedback to the program both spontaneously and when requested.
- Perform an academic self-assessment at least twice per year.
- Participate in curriculum development through the work of standing communities.
- Develop continuing quality improvement projects in conjunction with residency and faculty

### **Program Advancement/Promotion**

#### Promotion Criteria from PGY-1 to PGY-2

Following at least twelve (12) months of training, the Residency Advisory Committee will make a recommendation for promotion to PGY-2 status based on the following criteria:

#### Patient Care

Regarding patient care, the intern will:

- Role-model competent whole person care to other residents and medical students.
- Have documented participation in at least 20 deliveries prior to assuming continuity maternity patient coverage OR participate in an active plan to ensure adequate total deliveries (such as an elective in OB).
- Demonstrate the ability to independently perform a complete history and physical exam, write appropriate orders, and appropriately document the hospital course for inpatients.
- Have demonstrated competency in basic procedures to include Pap smears, I&D, suturing, and wet preps as confirmed by clinical preceptors.

### Medical Knowledge

Regarding medical knowledge, the intern will:

- Satisfactorily pass all required rotations.
- Have achieved at least 10th percentile on the composite score of the Family Medicine In-Training Exam or demonstrated equivalent level performance on a program-administered reassessment.
- Have achieved a minimum of the level 2 milestone on the MK-1 and MK-2 subcompetencies.
- Have taken the USMLE Step III examination by the last day of the 12<sup>th</sup> month of training.

### Practice-Based Learning and Improvement

Regarding practice-based learning and improvement, the intern will:

- Demonstrate the ability to give and receive feedback and make improvements in his/her patient care.
- Demonstrate an ability to assimilate and apply medical information to patient care.
- Participate in forums that discuss and improve systems for medical education, patient care, or resident well-being.

### Interpersonal and Communication Skills

Regarding interpersonal and communication skills, the intern will:

- Demonstrate the ability to communicate respectfully and effectively with patients, faculty, staff, and colleagues in a manner that will be conducive to assuming a supervisory role by October of the second year.
- Demonstrate adequate documentation skills to include checkouts, on- and off-service notes, and outpatient charting.

### Professionalism

Regarding professionalism, the intern will:

- Have demonstrated adequate participation in academic and professional activities such as conferences, rounds, and meetings, and pursuit of certification exam completion.
- Model professional behavior to students in clinic and rotations.
- Have achieved at least the minimum required conference attendance of 75%.

- Demonstrate adherence to policies regarding procedural documentation.

#### Systems-Based Practice

Regarding systems-based practice, the intern will:

- Demonstrate ability to coordinate care with case managers and other resources.
- Demonstrate cooperation within the medical system to ensure excellent patient care as seen by timely completion of medical records, charting, and follow-up.

#### Promotion Criteria from PGY-2 to PGY-3

Following at least 20 months of training, the Clinical Competency Committee will make a recommendation for promotion to PGY-3 status based on the following criteria:

#### Patient Care

Regarding patient care, the resident will:

- Be a role-model of competent and compassionate whole person care to junior residents and medical students.
- Have documented participation in adequate continuity deliveries to assure a total of 20 by graduation OR will participate in a plan to achieve this goal.
- Demonstrate the ability to supervise a complete history and physical exam and oversee appropriate orders for hospital care.
- Assume an active role in diagnosis and treatment plans which is based on sound medical knowledge.
- Have documented adequate procedural competency to supervise the in-patient team adequately, including competency on knowledge and skill domains on EKG interpretation, ICU management, code management, etc.

#### Medical Knowledge

Regarding medical knowledge, the resident will:

- Satisfactorily pass all . Evaluations from each rotation must be received. A verbal report from the preceptor of his or her intent to give a passing grade may be taken for the final rotation of the year, if the committee meets prior to the completion of that rotation.
- Have achieved at least 25<sup>th</sup> percentile on the composite score of the Family Medicine In-Training Exam OR be participating in a program for academic enhancement.

- Have passed USLME Step 3 by his or her 20<sup>th</sup> month of training.

#### Practice-Based Learning and Improvement

Regarding practice-based learning and improvement, the resident will:

- Demonstrate the ability to give and receive feedback and make improvements in their patient care and practice.
- Demonstrate an ability to independently locate, assimilate, and apply medical information to patient care.
- Participate in forums that discuss and improve systems for medical education, patient care, or resident well-being.

#### Interpersonal and Communication Skills

Regarding interpersonal and communication skills, the resident will:

- Have the ability to role-model respectful and effective communication with patients, faculty, staff, and colleagues.
- Facilitate continuity of care through communication and documentation skills such as patient handoffs, on- and off-service notes, and telephone/message documentation.

Demonstrate teaching and management skills to effectively coordinate the teaching service and to teach junior residents and student learners

#### **Program Graduation Criteria**

The following graduation criteria apply to the PGY-3 level. The resident must:

- Complete and pass all required rotations.
- Not have any professionalism or ethical issues that preclude him or her from being an independent practicing physician in the opinion of the CCC.
- Be continually eligible to practice medicine on a limited license in Georgia.
- Be compliant with all MSM Family Medicine Residency Program policies including, but not limited to, being up to date with his or her duty hour logging.
- Have completed and presented an approved research project.
- Have completed and logged all required procedures.
- Have seen and documented at least 1,650 continuity patients.
- Have completed all clinic patient notes and be cleared by the medical records department.

- Complete the GME, HR, and MSM Family Medicine exit procedures.
- Have achieved milestone levels for all competencies and subcompetencies demonstrating the ability to practice independently.

The program director must determine that the resident has had sufficient training to practice medicine independently as evidenced by meeting the goals above and a final summative assessment.

Upon fulfillment of these criteria, the program director must certify that the resident has fulfilled criteria, including the program-specific criteria, to graduate. The resident must demonstrate professionalism, including the possession of a positive attitude and behavior, along with moral and ethical qualities in an academic and/or clinical environment. The resident must satisfactorily meet all ACGME standards as outlined in the program requirements.

To signify completion of the listed criteria, the program director will certify that the resident has completed all ACGME and program-specific requirements for graduation and that he/she has been determined by the Program faculty, faculty advisor, and CCC to be competent for independent practice.

### **Evaluation of Faculty**

#### ACGME Requirement

As per the ACGME requirements, at least annually, the program must evaluate faculty performance as it relates to the educational program. These evaluations should include a review of the faculty's clinical teaching abilities, commitment to the education program, clinical knowledge, professionalism, and scholarly activities. This evaluation must include at least annual written confidential evaluations by the residents. In compliance with this requirement, the MSM Family Medicine Residency Program follows the following process for faculty evaluation.

#### Program-Specific Process

Departmental residency faculty members are evaluated by residents on a quarterly basis using the Resident Evaluation of Faculty tool in New Innovations. Individual means for each domain are calculated for each faculty member and are compared to the overall faculty means. Inpatient attendings are also evaluated by residents each time they rotate on the Family Medicine Wards service using the Inpatient Attending Evaluation Form. Written feedback is provided to each faculty member every six months in the form of the Semi-Annual Evaluation of Faculty Member by Residency Program form, which can be found in the Appendix of this document. The evaluation is designed to assess faculty members' clinical teaching abilities, commitment to the educational program, clinical knowledge, professionalism, and scholarly activity. Annually, during the months of April-June, the Program Director discusses the form with each Program faculty member and a faculty development plan is devised as needed based on the content of the evaluation. These evaluations and development plans are remitted to the Department Chair for integration as part of the faculty members' evaluations by the Chair.

Quarterly batching of evaluations and semi-annual reporting to faculty of aggregated evaluations is done to assure residents of the anonymity of their evaluations. However, residents are encouraged to immediately communicate pressing concerns regarding attending performance to the Program Director or, if anonymity is desired, using the “on the fly” option for the NI faculty evaluation. Such reports are handled with the individual faculty member or the faculty as a whole as is appropriate to provide necessary faculty development by the Program Director. Serious concerns may require intervention by the Department Chair. This exception is intended to allow for timely correction of faculty member deficiencies.

#### Program Director Evaluation

The program director reports directly to the Chair of the Department of Family and indirectly to the Associate Dean for Graduate Medical Education. The Program Director is evaluated by the residents through the annual Institutional GME Survey and by the Chair of the Department of Family Medicine. Both are confidential evaluations.

#### **Evaluation of Program and APE Process**

##### GME Annual Program Evaluation

The Morehouse School of Medicine Office of Graduate Medical Education maintains oversight of the program evaluation process, as detailed in the section 4.2.3 of the MSM GME Policy Manual.

##### Program-Specific Annual Program Evaluation

All MSM programs are evaluated confidentially and anonymously on an annual basis by residents and faculty under the oversight and direction of the GME office. The results of this annual evaluation are used by the Family Medicine Residency Program to develop an annual program improvement plan which is monitored and, when appropriate, adjusted by the Program Evaluation Committee, which meets quarterly. The Program Evaluation Committee (PEC) is an ACGME-mandated committee which, along with the Program Director, is responsible for generating the Annual Program Evaluation and Improvement Report which documents the program’s extensive review of resident performance, faculty development, graduate performance, program quality, and program compliance with ACGME Requirements based on its ongoing monitoring process. The PEC then uses this document over the course of the year as a guide to for its ongoing evaluation of program effectiveness, compliance, quality, and efficiency.

#### **Program Evaluation Committee (PEC)**

The ACGME requires that the program is evaluated and that the Program Director appoint a Program Evaluation Committee (PEC) to assist in reviewing the program on an annual basis. The roles and responsibilities of the PEC are described in the Program Evaluation Committee Policies section of the Appendix.



## GME Leave Policy

The MSM Department of Family Medicine Residency Leave Policies are consistent with the MSM Human Resources and GME Leave Policies. Please reference the GME Policy Manual at <http://www.msm.edu/Education/GME/index.php>.

### **Benefit Time (Vacation/Sick/Other)**

The types and number of allowable days for each type of leave are described below. Of note, the ACGME Family Medicine Program Requirements dictate that no more than 30 days may be taken away from the program during a single program year. Time away from the program for more than thirty days during a program year will result in an extension of training dates.

#### Vacation Leave

Each resident is given 15 days of vacation annually. Third-year residents can take up to five (5) days for exploring employment opportunities. Time needed in excess of five (5) days should be taken from vacation time.

- Vacation may be taken in 5-day increments.
- Vacation is not permitted on half-month block rotations.
- Vacation cannot be taken during the following restricted rotations: Family Medicine Wards Service, ICU, Pediatric Ward, Pediatric ER, and Internal Medicine Wards rotations.
- Leave requests must be submitted 110 days prior to the anticipated leave.
- A fair and equitable manner will be used when approving time off requests.
- Annual vacations must be taken in the year for which the vacation is granted; vacation periods do not carry over from one year to another.
- No two vacation periods may be concurrent from one PGY year into the next (e.g., last month of the PGY-2 year and first month of the PGY-3 year in sequence).

#### Sick Leave

Compensated Sick Leave is 15 days per year. This time can be taken for illness for the resident or for the care of an “immediate” family member.

- Sick leave is not accrued from year to year.

- Available sick leave, 15 days maximum, and/or available vacation leave, 15 days maximum, may be used to provide paid leave in situations requiring time off for the purpose of caring for oneself or an immediate family member due to serious health conditions.

#### Administrative Leave

Granted at the discretion of the program director, administrative leave may not exceed ten (10) days per twelve-month period.

#### Holiday Leave

Morehouse School of Medicine observes the following eleven days as official holidays: New Year's Eve, New Year Day, MLK Day, Good Friday, Memorial Day, July 4<sup>th</sup>, Labor Day, Thanksgiving, the day after Thanksgiving, Christmas Eve, and Christmas Day. All Morehouse Healthcare clinics and administrative offices are closed on these days. However, time off for a holiday is based on a resident's rotation assignment. When rotating on a clinic or service that closes due to a holiday, the resident may take that time off as paid holiday leave with approval of the program Director. As hospitals are considered essential services, a resident may be required to work on a holiday. The resident must clarify with his/her assigned service whether or not he/she is required to work on a holiday.

#### Educational Leave

Time away from the residency program for educational purposes, such as workshops or CME activities, are not counted as absences, but should not exceed five days annually. The Program Director must approve educational conferences three (3) months (90 days) before the month in which the conference is to take place. The total time away within any academic year cannot exceed 30 days as per ACGME requirements. The program assistant in the Residency Office handles travel arrangements for CME.

#### Family and Medical Leave

MSM provides job-protected family and medical leave to eligible residents for up to 12 workweeks of unpaid leave during a 12-month period based on the following qualifying events:

- For incapacity due to pregnancy, prenatal medical care, or child birth;
- To care for the employee's child after birth, or placement for adoption or foster care;
- To care for the employee's spouse, son, daughter, or parent, who has a serious health condition; or
- For a serious health condition that makes the employee unable to perform the employee's job.

Eligible residents who care for covered service members may also be eligible for up to 26 workweeks of unpaid leave in a single 12-month period.

Residents are eligible for FMLA leave if they have worked for MSM for at least one (1) year, have worked 1,250 hours over the previous 12 months, and have a qualifying event as outlined above. Residents must direct all questions about FMLA leave to the Human Resources Department.

#### Leave without Pay

When possible, requests for leaves of absence without pay shall be submitted in writing to the Program Director far in advance of the proposed leave. Such requests must include the reason and duration for the proposed leave. The Program Director must discuss the implications of the leave, including possible prolongation of the program and should ensure that the resident understands these implications. If the resident decides to move forward with the request, the MSM Human Resources Department must review the request for feasibility and applicable criteria before the leave is granted. The Office of Human Resources shall also advise the Program Director and Resident of all details and procedures.

#### Other Leave Types

All other leave types (e.g., military, bereavement, jury duty, etc.) are explained in detail in MSM's Policy Manual which is available on the Human Resources Department Intranet webpage.

#### **Program Leave Process**

Leave time is any time away from the residency training program not related to educational purposes. Leave time must be approved 110 days in advance. Leave time does not carry over from one contract year to another.

Per ACGME requirements, a resident cannot take more than 30 days away from the program without requiring extended time in the program. Residents are expected to perform their duties as resident physicians for a minimum period of eleven months each calendar year. Therefore, absence from the program for vacation, illness, personal business, leave, etc. must not exceed a combined total of one (1) month per academic year.

Absence from the residency program in excess of one (1) month within the academic year must be made up before the resident advances to the next level, and time will be added to the date of completion of the required 36 months of training. (See AAFP Time Away from Program protocol)

The resident must complete a Leave Request form for any time off. Forms must be completed by the resident and submitted to the chief resident for approval. It is the resident's responsibility to get the chief resident's signature and forward the forms to the residency coordinator and the director for approval.

If any changes in night call schedule are necessitated by the leave time, it is the resident's responsibility to contact the chief resident and arrange for coverage. The names of the physicians covering call and clinic responsibilities must appear on the Leave Request Form and must be signed by that resident agreeing to cover the call or clinic responsibility. Notification must be given to the operator. Third-year residents are

advised that there may be no leave during the last three weeks of residency except for extreme circumstances. Director approval is required.

#### Notice of Intent to Take Leave

The resident is required to give the residency director a minimum of 110 days written notice and preferably a four-month advance written notice for vacation, CME, and all other leave stating:

- The reason of the leave is required (i.e. vacation, sick, etc.) If anticipated maternity leave, due date or adoption proceedings date shall be included
- The date leave will begin and the date the resident will return to resume his or her training

A physician's statement of the condition requiring sick leave (including maternity) or a legal statement regarding adoption or foster care must accompany the notice of intent.

#### Return to Duty

For leave due to parental or serious health conditions of the resident or a family member, a physician's written "Release to Return to Duty" or equivalent is required with the date the resident is expected to return to resume his or her residency. This information is submitted to the Human Resources Department (HRD).

When applicable, the residency program director will record in writing the adjusted date required for completion of the PGY and/or the program because of extended resident leave. One copy is placed in the resident's educational file and a copy is submitted to the Office of Graduate Medical Education (GME) to process the appropriate Personnel Action.

#### Program Leave Limitations

Leave away from the training program includes the total of all leave categories taken within an academic year. This includes uncompensated Federal Family and Medical Leave and other Leave without Pay (LWOP). All/any should not exceed 30 days per year.

**The resident may be required to make up some portion of his or her share of call nights upon return to duty.** Advanced notification of anticipated leave will enable the chief resident to incorporate the resident's absence into the clinic and call schedule and hopefully arrange full coverage. The chief resident will make any reassignments of call, as needed.

For successful completion of the program on time, and for Board eligibility in April of the PGY3 year, the American Board of Family Medicine does not permit more than 30 days leave time per year. Time away of more than 30 days will result in ineligibility to sit for the ABFM Board Examination in April of the PGY3 year. In rare instances, the PD may, at her discretion, override this rule and permit a resident to take the exam with his/her class. Leave time greater than 30 days per academic year is at the discretion of the director.

## GME Moonlighting Policy

The MSM Family Medicine Residency Program moonlighting policy is consistent with the policy outlined in the GME Policy Manual.

### Program Moonlighting Guidelines

Moonlighting is permitted for PGY-2 and PGY-3 residents in good standing, with an independent medical license and proper malpractice coverage. Residents wishing to moonlight must obtain written permission from the program director. See the Moonlighting Policy for additional details. Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program nor interfere with duty hours. Internal and external moonlighting is considered part of the duty hour limitations.

Moonlighting is clinical work done outside the scope of our program by a resident. Its advantages (extra income, experience in other settings, etc.) must be weighed against potential negatives (less free time, sleep, and time with significant others). As stipulated by the ACGME Family Medicine Residency Program Requirements, moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program. Moonlighting activities are monitored by the program director to ensure that the quality of patient care and the resident's educational experience are not compromised.

Family Medicine PGY-2 and PGY-3 residents may be permitted to moonlight. Written permission from the program director must be granted prior to engaging in any moonlighting activities. The following conditions must be met in order for the program director to consider approving a resident request to moonlight:

- The resident must be in good academic standing in the program. He or she must not be in academic remediation or probation. The resident must also fulfill all administrative requirements of the program (e.g., prompt dictations, clinic note completion, handling phone messages and lab results in a timely manner, etc.).
- The training license and training DEA number may not be used to practice medicine outside of the residency program.
- The resident must have:
  - Valid, full medical license from the State Medical Board of Georgia, as residents may not practice medicine outside of our residency program under the State of Georgia Training Certificate; and
  - A personal DEA certificate/number (the DEA number issued by the hospital for residents may be used only in carrying out clinical duties that are part of the residency program, and may not be used for moonlighting purposes).
- The resident must arrange for his or her own malpractice insurance; the resident can either pay for this insurance personally or it can be provided by the entity employing the resident for the

moonlighting. The Morehouse School of Medicine malpractice insurance plan does not cover any activities outside of a residency program.

- Moonlighting is restricted to one (1) shift per week. It should not interfere with patient care nor be so excessive that the resident is too tired to learn and/or to perform the residency requirements. The combined hours of residency and moonlighting should not exceed 80 hours per week.
- The resident may not moonlight during normal duty hours, as defined by his/her rotation. Further, the resident is not permitted to moonlight between 7:00 a.m. and 5:00 p.m. on Monday through Friday, while on call, or on the day post-call.

The resident who meets the conditions above and desires to moonlight must submit a written request (see appendix) to the program director to receive permission to moonlight. This request must document that the resident meets the conditions and that he or she will follow the moonlighting policy. The resident must also provide details as to where and how many hours each week he or she plans to moonlight. The program director will then review the request; if there are no concerns, the program director will then give the permission to moonlight.

When considering the request, the program director will take into account the resident's workload, academic standing, and compliance with residency requirements. If the resident is given permission, he or she must follow all rules and policies as established by the program. Privileges may be rescinded if the rules are not followed, if the resident does not include moonlighting hours in his/her duty hour log, if moonlighting activities are deemed to be excessive, or if the resident is placed on academic remediation or on probation.

The Moonlighting Request form can be found in the Appendix section of this document.

## **GME Physician Impairment and Health (Substance Abuse) Policy**

The stress associated with residency is well recognized. Morehouse School of Medicine offers an Employee Assistance Program (EAP) through Care24, which is available to residents and their family member by self-referral. Services provided in the EAP include but are not limited to mental health, family counseling, and drug awareness and assistance. Additional information about the program is available in the Human Resources Department at 404-756-1600 or 404-752-1846, or directly from CARE 24 at 1-888-887-4114. ) 271-7788.

The Family Medicine Residency complies with the GME Physician Impairment and Health (Substance Abuse) Policy that can be found on the website at <http://www.msm.edu/Education/GME/index.php>.

## Professionalism and Ethics Policy

The MSM Family Medicine Residency Program adheres to the GME Professionalism policy which can be found at <http://www.msm.edu/Education/GME/index.php> through the GME Policy link on the GME webpage.

Ethics is the systematic application of values. Medical ethics focuses on the prevention, recognition, clarification, and resolution of conflicts associated with medical issues and emphasizes the basic values that underlie clinical interactions, such as honesty, integrity, the primacy of the commitment to the patient's well-being, and compassion.

Residents should:

- Know how to inform patients and obtain voluntary consent for the general plan of medical care and specific diagnostic and therapeutic interventions
- Know what to do when a patient refuses a recommended medical intervention in both emergency and non-emergency situations
- Know what to do when a patient requests ineffective or harmful treatment
- Be able to assess a patient's decision-making capacity
- Know how to select the appropriate surrogate decision-maker when a patient lacks decision-making capacity
- Know the principles that apply when the physician must decide for a patient when the patient lacks decision-making capacity and there is no appropriate surrogate decision-maker
- Be adept at broaching the subject of a dying patient's eventual death and discussing with the patient the extent of medical intervention at the end of life
- Understand and apply the ethical principle of balancing obligations to patients with one's self interest
- Know how to deal with the following forms of potential conflict of interest:
  - Induced demand (physician's ability to create a demand for his or her service)
  - Accepting gratuities from manufacturers
- Know the physician's obligation when he or she suspects that another healthcare provider is abusing alcohol or drugs or is professionally incompetent

In the event that a resident is uncertain about how to handle any of the situations above, consultation with the attending physician is required.

Key elements of Professionalism that must be upheld by residents include completing administrative duties including but not limited to responding to email, completing duty hour and other logging, and completing evaluations by established deadlines; adhering to the dress code; and treating others respectfully. The Program Professionalism Agreement is included in the Appendix of this document and must be review and signed by all residents.

### **Regulatory Compliance**

Residents are required to comply with the following laws. The MSM Office of Compliance mandates annual compliance training for review of these laws and attestation of understanding and duty to follow them.

- False Claims Act—imposes civil liability for making false or fraudulent claims to the government for payment;
- Anti-Kickback Statute—prohibits the offer, payment, solicitation, or receipt of any form of remuneration in return for the referral of Medicare or Medicaid patients;
- Stark I and II Physician Self-Referral Law—prohibits physicians from making certain Medicare referrals to entities with which the physician or his or her family members has a financial relationship;
- Emergency Medical Treatment and Active Labor Act (EMTALA)—all patients must receive emergency medical treatment regardless of ability to pay; can be transferred only after being stabilized;
- Health Insurance Portability and Accountability Act (HIPAA)—ensure the confidentiality and privacy of protected health information (PHI) and electronic PHI.

### **Dress Code**

Standard dress while on duty consists of professional-appearing clothes and a clean white lab coat. The MSM ID badge should be worn as part of the uniform. Scrubs should not be worn in public establishments nor in continuity clinic. Hospital scrub suits are permissible at appropriate times within the hospital. Appropriate areas include Obstetrics, Labor and Delivery, Emergency Room, Surgery, and while on call at night. Male residents are to wear dress shirts and tie or shirt-jacket; clean, unwrinkled slacks (no jeans). Female residents are to wear dresses, skirts, pantsuits, or slacks with modest and professional-appearing blouses, hosiery, and closed toe/heal shoes appropriate for professional wear. Residents must abide by MSM, GME, and participating sites' (hospitals) dress codes, rules and standards. The MSM GME dress code is documented in the GME Policy Manual.



## Quality Improvement & Patient Safety Guidelines

Training in Patient Safety and Quality Improvement is an essential component of family medicine residency education. It is the focus of the Systems Based Practice -2 (SBP-2) subcompetency. As such, participation in the following PS/QI activities is required.

1. Annual completion of Institution of Healthcare Improvement (IHI) Open School PSQI modules. Instructions for module completion and the link for access to these modules are provided by the Program through the GME office. Modules must be completed before the posted deadlines.
2. A PS/QI project must be completed as part of the Practice Management and Community Health Rotations
3. After each month on the Family Medicine Wards service at Atlanta Medical Center-South, a case report must be presented during Wednesday didactics. The report must include a discussion of PS/QI issues related to the case.
4. As a requirement of program completion, each resident must complete a research project, described in the Research/Scholarly Activity Guidelines section of this document. These projects are expected to have a PS/QI implication.
5. Residents must report negative events and near misses that occur in the hospital through the respective hospitals formal reporting mechanism, including documenting the event through the hospital's electronic reporting portal.
6. Negative outcomes/events that occur in the Comprehensive Family Healthcare Center should be reported through the MSM Office of Compliance hotline at (855) 279-7520 and [on-line reporting system](https://secure.ethicspoint.com/domain/media/en/gui/44523/index.html) at <https://secure.ethicspoint.com/domain/media/en/gui/44523/index.html>.
7. Physician-to-Physician patient handoffs must occur at each change of shift, change of service, transfer of care (including outpatient office to hospital transfers). A full discussion of patient handoffs is included in the Transition of Care section of this document.

## Research/Scholarly Activity Guidelines

A scholarly project is required of each resident prior to completion of residency training. Residents will not be approved for graduation without the project being received and approved by the director of research based on criteria communicated to residents. The resident is responsible for selecting the faculty who will be assisting with his or her scholarly activities through the research director, Gregory S. Strayhorn, MD, PhD.

Each resident is required to have a faculty discussant for his or her QI/Research project. During the Research Forum, held in June, each resident will receive 15 minutes to present, followed by a 10-minute discussion. Faculty research advisors are expected to participate in the discussion.

Presentations should be developed in the following format:

### **Introduction:**

- Question addressed and its importance stated
- Conceptual model
- Testable hypothesis(es)

**Methods:**

- Sample—who was studied?
- Dependent/outcome variable
- Independent variable(s)—what predicts or is associated with the outcome variable?
- Co-variables—did you control for variables (factors) that might affect the association between the independent and dependent (outcome) variable?
- Measurement—how were variables measured? What are the validity and/or reliability of measurement tool?
- Analysis—what statistical analytic methods were used to describe your sample, determine the distribution of responses, and test the hypothesis(es)?

**Results:**

- Characteristics of sample
- Distribution of responses for independent/dependent/co-variables, i.e., what percentage of residents vs. faculty responded to a different domain:
  - Of the variables
  - Results of test of hypothesis(es)

**Discussion:**

- A brief restatement of findings (results)
- Interpretation of results—what do they suggest?
  - How are they consistent with what is known?
  - How do they differ with what is known and why?
  - What are the study's strengths and limitations?

**Conclusion:** Recommendations based on results

In addition to the scholarly research project described above, each resident completes a PSQI “mini-project” during the PGY-1 Practice Management and PGY-2 Community Health rotations. For these projects, the resident identifies an issue in the clinic with a patient safety implication and develops an intervention to improve patient safety related to the issue.

Residents are also required to complete all Institute for Healthcare Improvement (IHI) Open School PHQI modules during each year of training.

Finally, writing for publication is highly encouraged through authorship of case reports on patients managed on the Family Medicine wards service. Each faculty member is expected to identify, with the resident team, at least one patient during his/her coverage of the service whose case can be presented in a case report. The attending-resident co-authored case reports are to be written within 6 weeks of completing the inpatient service.

## Supervision Policy

### GME Supervision Policy

All patient care is supervised by qualified Family Medicine faculty physicians who are appropriately credentialed and privileged. The faculty physician is ultimately responsible for patient care. Information to identify the appropriate supervising faculty physician is available at all times via the schedule in New Innovations. A schedule is also posted in the CFHC nurse’s station. Residents and faculty members should inform patients of their respective roles in patient care.

The program director and MSM Graduate Medical Education Committee (GMEC) will ensure that supervision is consistent with provision of safe and effective patient care and the educational needs of residents. The program director will perform ongoing assessment for adequate and appropriate supervision of residents at all times. Residents will be provided with rapid, reliable systems for communicating with supervising faculty. Faculty schedules are structured to provide residents with appropriate supervision and consultation. All faculty contact numbers are posted in the Departmental Directory which is circulated by email annually and after each update. The directory is also posted in the Comprehensive Family Healthcare Center resident work area, the call room, and the Residency office.

Supervision is exercised through a variety of methods. Some activities require the physical presence of the supervising faculty member. For some aspects of patient care, the supervising physician is a more advanced resident. Supervision can be provided via the immediate availability of the supervisor or, in some cases, by phone or electronic modalities. On rare occasions, supervision may include post-hoc review of resident-delivered care with feedback.

To ensure oversight of resident supervision and progressive levels of authority and responsibility, the residency uses the following classification of levels of supervision, consistent with ACGME guidelines:

- Direct Supervision—the supervising physician is physically present with the resident and patient.

- Indirect Supervision—with direct supervision available, where the supervising physician is **not** physically present, but is immediately available to provide direct supervision by phone or electronic modalities
- Oversight—the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

ACGME requires that all patient care **must be** supervised by approved clinical faculty. Faculty schedules must be structured to provide residents with **continuous supervision and consultation**. Lack of supervision or access to attendings must be reported to the program director and/or department chairperson.

Direct supervision is required for all procedures in the CFHC continuity clinic and AMC-S Family Medicine Ward service.

**Progressive Authority & Responsibility**

- Preceptors are expected to teach and provide appropriate and timely feedback to the Family Medicine residents in the preceptor’s room.
- If for any reason the preceptor cannot be on time, he or she should contact the clinic. If no one in the office can be contacted, the preceptor should then contact the program director directly so that arrangements can be made.

Levels of supervision are outlined in the following table.

**Levels of Supervision**

Level of Authority	Direct Supervision	Indirect Supervision	Supervisor: Senior Resident	Supervisor: Attending
<b>Setting</b>				
<b>OB</b>				
● High -risk patient	A, D	A, B, D	1	1

● Admission	A	B, C	1, 2	1, 3
● Labor Check	A	B, E	1, 2	1, 3
● Second Stage of Labor	A, D	A, B, D	1	1
● Change of Condition	A	B, E	1, 2	1, 3
<b>Inpatient</b>				
● Admission	A	B, C	1, 2	3
● Change of Condition	A	B, E	1, 2	3
● Transfers to New Level of Care	A	B, C, E	1, 2	3
● Hospital Transfer	A	B, E	1, 2	3
● Peds	A	B	n/a	2
● Surgery	A	B	n/a	2
● Emergency	A	B	n/a	2
<b>Ambulatory</b>				
● FMP	A	B	n/a	1, 2
● Other (MSK, Beh, etc.)	A	B	n/a	1, 2
● Home visits	A	B	n/a	1, 3, 4
● SNF	N/A	B	n/a	2

**Key:**

A = Immediate supervisor present during patient encounter

B = Discuss patient with immediate supervisor; immediate supervisor to see patient

C = Call Attending; Attending to see patient and review care in future

D = Discuss with Attending; Attending to become direct supervisor immediately

E = Discuss patient with supervisor; supervisor will review documentation, may or may not see patient

**Supervisor:**

- 1 = Direct supervision
- 2 = Indirect supervision with direct supervision immediately available
- 3 = Indirect supervision with supervision available
- 4 = Oversight

ACGME requires that all patient care **must be** supervised by approved clinical faculty. Faculty schedules must be structured to provide residents with **continuous supervision and consultation**. Please report lack of supervision or access to your Attendings, to the program director and/or department chairperson.

### **Guidelines for When Residents Must Communicate with the Attending**

Residents must communicate with the attending to discuss all hospital admissions at the time of admission. Each patient seen in the clinic must be discussed with the supervising attending during the visit or before the end of the clinic session as appropriate. Additionally, if the resident is uncomfortable or uncertain about how to manage a patient due to the patient's acuity or the resident's level of medical knowledge or experience, the resident must communicate with the attending if guidance from an upper level resident is not sufficient. All procedures must be directly supervised by the attending physician.

## **Transition of Care Policy**

### Rationale

The primary objective of a "hand-off" is to provide accurate information about a patient's care from one physician to another physician who is assuming responsibility for the care of the patient to ensure safe continuity of care. Information transmitted in the handoff includes treatments, services, current condition, any recent or anticipated changes, and a to-do list for tasks that should be completed during the time that the resident will be caring for the patient. The information communicated during a hand-off must be accurate in order to ensure patient safety goals.

This policy conforms to the Joint Commission's National Patient Safety Goal 2E.

### Scope of Responsibility

This policy applies to Family Medicine resident physician hand-offs whenever there is a change in medical personnel charged with the medical care of the patient. Information transmitted during physician hand-off is stated in the "Rationale" section. Opportunities to ask and respond to questions must occur during hand-off.

### Hand-Off Communication Procedure

The following conditions are affected by this policy:

- Assignment of the newly admitted patient to the Family Medicine service.

- When a patient is admitted to the Family Medicine service, the Emergency Department (ED) attending contacts the Family Medicine Attending to provide handoff. If the attending accepts the patient to the service based on sign-out from the ED physician, he/she will contact the resident on duty to evaluate and admit the patient. In the event that the appropriateness for admission is not clear based on the report from the ED attending, the FM attending will contact the resident on duty to evaluate the patient and discuss the patient with the attending who will then determine whether admission or clinic follow-up and outpatient management is most appropriate. Upon accepting deciding to admit the patient, the attending will formally accept responsibility for the care of the patient and transfer of care from the ED to the appropriate hospital unit occurs.
- On Monday to Friday, between 7:00 a.m. and 5:00 p.m. the resident referenced above will be the resident designated to admit the next patient as agreed by the team. On Monday to Friday between 5:00 p.m. and 7:00 a.m., this will be the night float resident.
- Transfer of patients between the daytime team and night float resident.
  - Hand-off communication occurs at 5:00 p.m. and at 7:00 a.m. between the daytime and night float teams (daytime team signs off to the night resident at 5:00 p.m. and vice-versa at 7:00 a.m.).
  - Both verbal and written communication is conducted. All patients are documented in the electronic sign-out list and distributed to the covering team. This will also be an opportunity to ask and respond to questions.

#### Transfer of patients to new rotating residents.

- On the last day of the rotation, the inpatient team writes “off service notes” on all patients. The note includes each patient’s initial presentation, hospital course, pertinent lab and study results, and current status including any pending results or consults.
- A verbal sign-out is also given at 6:00 p.m. on the night before the new team begins.
- The outgoing PGY-3 resident signs out all patients to the oncoming PGY-3 and highlights the patients that he or she is following.
- The PGY-2 also signs out his or her patients to the oncoming PGY-2.
- Any changes that occur overnight will be communicated by the night float resident to the oncoming day team as previously described.

#### Evaluation Methods

- The Attending must observe at least one change of shift handoff in person and two by telephone.
- Each resident is evaluated based on meeting hand-off expectations in the following areas: environment, standard handoff time, use of the SBAR transition of care presentation format, appropriately identifying patient details requiring special attention by the receiving resident, and

confirmation that receiving resident understands the SBAR content on all patients by presenting back.

- The Attending is expected both to give immediate informal feedback on the witnessed handoffs and to complete the formal evaluation in New Innovations.
- If any resident is not considered to be competent to give or receive handoff after the required minimum of observed handoffs by the attending, the senior resident and attending must provide additional education to the resident. The attending must continue to observe handoffs until each inpatient team resident is determined to be able to give hand off competently. The ability to give competent handoff is a requirement of passing the Family Medicine Wards rotation.
- Residents should anonymously report breakdowns/problems in the handoff process for continued improvement.

## **GME USMLE (and COMLEX) Examinations**

The MSM FM Residency Program USMLE step 3 policy is consistent with that of the GME policy documented in the GME Policy Manual. All Family Medicine residents are required to sit for USMLE Step III by the last working day of the twelfth month of training and must pass the examination by the last working day of the twentieth month (February of the second year in a normal appointment cycle.

If unable to pass the examination by the twentieth month, the resident will receive a letter of non-renewal of contract from the program on March 1<sup>st</sup>. However, if the resident passes USMLE Step III between months 21 and 24, the resident will receive a reappointment letter upon receipt of results provided that failure to pass USMLE III was the sole reason for nonrenewal.

## **ACGME Specific Program Guidelines**

The MSM Family Medicine Residency Program abides by the current ACGME Program Requirements. The ACGME Program Requirements for Graduate Medical Education in Family Medicine document available at the following link:

[http://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/120\\_family\\_medicine\\_2016.pdf](http://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/120_family_medicine_2016.pdf)

### **Rotation Goals and Objectives**

Milestone-based goals and objectives have been developed for all rotations and are accessible to residents and faculty through the Resources tab in New Innovations.

### **Conference/Didactics Policy**

In accordance with ACGME requirement IV.A.3, the program holds regularly scheduled didactic sessions on Wednesdays from 1:30pm to 5:00pm. These sessions are required for all residents except those rotating on certain rotations or under certain circumstances as outlined below.



- When urgent clinical responsibilities or official residency functions preclude a resident from attending a required conference, the residency program director, the associate residency director or the program manager must be contacted to “excuse” the absence.
- Scheduled vacations, out-of-town rotations, and Continuing Medical Education (CME).
- Residents on the following rotations (see below).
  - Internal Medicine (Grady Wards)
  - Intensive Care Unit (ICU)
  - Peds ER
  - Surgery
  - Pediatric Wards
  - Nursery

Didactics-Related Expectations:

- Attendance at all didactic sessions except as outlined above is mandatory and strictly enforced. Failure to attend may result in disciplinary action.
- The resident must submit an electronic evaluation of each session attended through New Innovations (NI).
- While on rotations on which the resident is not required to attend the Family Medicine Wednesday conferences, the resident is expected to attend the regularly scheduled conferences provided by the respective department unless otherwise assigned by the rotation director
- Family Medicine places high emphasis on the quality of its didactic programs. Our expectation is that residents who are scheduled to speak or present will do so in a professional and timely fashion. In the unfortunate event that a resident foresees that he or she will not be able to present (on vacation, CME, etc.), it is expected that the resident will contact the chief resident and the program assistant, Angel Allen, who coordinates didactics, to reschedule and ensure that the time will be covered with another well-prepared lecture.
- When a resident is scheduled to present, he/she must request an attending physician to be a discussant on the chosen topic. The resident must send the presentation to the Attending two weeks in advance for critical appraisal.
- When a resident is scheduled to present, he/she is required to provide topics with well thought out objectives to the program assistant two weeks in advance. Any additional articles that must be provided to the attendees of the didactic session should be sent to the Program Assistant a week in advance of the lecture.
- Attendance sheets are posted in the back of the conference room and it is the responsibility of each resident to sign into every didactic session. Sign-in sheets should reflect hourly attendance. Therefore, for any given Wednesday didactic, attendance will be taken for four (4) separate didactic hours. To get credit for attending a given didactic hour, the resident should be present for at least 80% (roughly) of that session.

**Family Medicine In-Patient Service Guidelines**

The Department of Family Medicine is responsible for the design and implementation of the Family Medicine In-Patient Service (FMIS). The Family Medicine In-Patient Service (FMIS) consists of patients who are admitted from the FMP and select patients admitted by the Eagle Hospital Physicians (EHP) group. Resident coverage for the teaching service is provided on a 24-hour-a-day, year-round basis.

All residents and interns on Family Medicine In-Patient Service are required to follow their patients at AMC-S with daily rounds and notes.

#### Daytime FMIS—Attending Staff and Volunteer Responsibilities

The attending staff is composed of Morehouse Family Medicine and EHP Attendings whose patients are on the teaching service. The Attending for the Family Medicine In-Patient Service will supervise the service, which will include the following duties:

- Perform daily rounds and write/attest notes on all patients on the FMIS.
- Encourage input from nursing staff, along with nutrition, social services, behavioral medicine, and health promotions faculty as indicated by patient care needs.
- Lead didactic sessions on family medicine issues in the inpatient setting.
- Organize patient care conferences on problem patients as needed.
- Review, edit, and sign dictated History & Physicals (H&Ps) and discharge summaries on all FMIS patients
- Review, edit, addend if needed, and attest resident progress notes on each patient
- Electronically sign all resident orders

#### FMIS Resident Teaching Responsibilities

All residents are expected to provide peer instruction through interaction in conferences, rounds, etc. Each resident will be responsible for medical student instruction in the third-year clerkship and the Introduction to Primary Care course held throughout the academic year. As part of the resident team, the resident is expected to act as a peer-level teacher in all circumstances. Residents are expected to work up patients with the medical student on call.

#### *Senior Resident Responsibilities*

The senior resident closely supervises the first-year resident, including:

- Directly observing H&Ps by the PGY-1 and teaching interviewing and physical exam skills, as needed
- Reviewing the H&P, orders, plan, and problem list with the PGY-1 on every admission prior to calling the attending to discuss the case

- Writing a brief resident admit note on each admission performed on Family Medicine patients by the PGY-1
- Discussing patient management when the PGY-1 is called about a FMIS patient
- Providing other assistance as requested by the PGY-1
- Responding with the PGY-1 to emergency calls/codes
- For morning report, the senior resident helps the PGY-1 select which cases to present and should review the cases with the PGY-1 to emphasize the salient points and to help educate the other residents regarding the management of the cases.
- The senior resident is responsible for helping lead morning report.
- The resident assigned to the team phone will be called by the service/hospitalist attending about potential Family Medicine admissions. During the month of July, while the PGY-1s are on service, the Chief residents will alternate to supervise the intern on the admission, including the performance of the H&P, review of the documented H&P, and development of the assessment and proposed orders before presentation to the attending.

#### Junior Resident Responsibilities

The PGY-1 performs H&Ps on admissions to the service and writes appropriate orders, problem lists, differential diagnoses, daily notes, flow sheets, and patient care plans with senior resident supervision.

The PGY-1:

- Follows the patient closely and develops a feel for the course of illness with its effects on the patient and family's psychological and physical states.
- Is prepared to participate in and contribute to didactic sessions on service patients.
- Coordinates the multi-disciplinary team in caring for the patient.
- Works with the team, patient, and family in preparing for discharge and follow-up. The PGY-1 prepares discharge patients and dictation on any patient he or she follows primarily.
- Should make arrangements for the patient who does not have another primary care physician, to come to see him or her for follow-up in the FMP.
- Participates in team rounds one weekend day (Saturday or Sunday) per week
- Should notify the senior resident that he or she needs help if the workload becomes unmanageable.
- Should utilize the team approach to facilitate learning comprehensive family medicine style of care.

- With the senior resident is not to be scheduled to the same clinic session, so one or the other can be available for patient problems as they arise.

### Eagles Hospitalist Admission Guidelines

These guidelines are designed to guide the relationship between the Family Medicine residents and the hospitalists to optimize the educational experience of residents and to avoid service over education. These guidelines address admission limits based on patient volume and severity, times of resident availability for admissions, volume-based transfers of care, and other details related to resident admission and management of hospitalist service patients.

#### *General Guidelines:*

- Floor Team Cap: 16 patients
- ICU patients count as 2 patients
- Individual Resident Cap: 8 patients
- Morehouse Service: **There is NO cap.** We continue to accept MSM patients and we will drop (stop following) Eagles patient the next day, to maintain a cap of 16.
- Morning report will be conducted by MSM Faculty and floor team on Fridays from 8:00 to 9:00 AM, there will be no Eagles admission during this period.
- During MSM rounds, the Floor Team can be called for Eagle admissions, unless there is a critical patient being managed at the time. The PGY3 resident should stay to complete rounds with the attending, and the PGY2 resident will take the admission. Otherwise, if both are PGY2s, then the residents can alternate. **On weekends, the residents should always stay to finish MSM rounds, and kindly inform the Eagle attending that you are still in rounds. You can suggest taking an admission later, or inform them that you will not be able to get to the patient for some time, until rounds are completed.**
- Residents will continue to dictate H&P and Discharge summary on all their patients.
- Eagles Hospitalist will update us each morning with a list of patients for each provider so the residents can discuss patients with the appropriate attending in charge of those patients.
- Eagles Hospitalists will be available to discuss hospital admissions and orders after the initial evaluation has been completed by the resident
- The Eagles Hospitalist will inform the resident of the appropriate hospitalist to whom to assign notes for co-signature on the day after admission when the night hospitalist is off duty
- Rounding time with Eagles will be at attending's convenience, but preferably before noon and must not interfere with Morehouse service attending rounds
- The Eagles attending will inform the resident of any order changes in the event of a major change in management from a previously discussed plan.

#### *Night Float:*

- 2 admissions every **EVEN** night, from 7:00 PM to 3:00AM

#### *Day Team:*

- Admit 2 patients daily, from 8:00 AM to 3:00 PM, 1 in the AM and 1 in the PM on Monday, Tuesday, Thursday, and Friday.
- On Tuesdays and Thursdays, **both admissions** must be before 12:00 pm or 1 admission before 12:00 and 1 in the afternoon. In other words, a maximum of one (1) hospitalist admission can be accepted on Tuesday and Thursday after noon.
- A maximum of 1 daytime admission can be accepted on Wednesdays and it must be before 10:30am to allow for completion of the admission H&P, orders, and dictation before noon conference

*Saturday:*

- Admit 2 patients per 24 hours

EXCEPTIONS:

By the end of the day on Thursday, if there are a total of 10 patients, including ICU, the floor team will:

- Inform the Eagle attending who is admitting that there are 10 patients
- Accept only **ONE** total admission **per 24 hours**, Friday through Sunday if the census remains at 10

On Friday through Sunday, if the census is less than 10 patients, there will be 2 admissions per 24 hrs. This rule also applies to Holiday Calls.

## Appendix

**APPENDIX A: Moonlighting Form**

**APPENDIX B: Hand-off Form**

**APPENDIX C: Acknowledgement of Promotion and PGY2-Specific Requirements**

**APPENDIX D: Acknowledgement of Promotion and PGY3-Specific Requirements**

**APPENDIX E: Clinical Competency Committee Policies and Responsibilities**

**APPENDIX F: Program Evaluation Committee Policies**

**APPENDIX G: Evaluation of Faculty by Residency Program Form**

**APPENDIX H: Resident Leave Request Form**

**Morehouse School of Medicine  
Family Medicine Residency Program  
Moonlighting Privileges Request Form**

Resident Name: \_\_\_\_\_ Date: \_\_\_\_\_

I am requesting permission to moonlight. I currently meet the following conditions:

- I am a resident in good academic standing in our program. I am not on academic remediation or probation, and I have promptly fulfilled all administrative requirements of the program.
- I have a valid Georgia medical license and DEA number (copies are attached).
- I have arranged for my own malpractice insurance for this moonlighting. I understand that Morehouse School of Medicine will not provide this coverage.
- I will not moonlight excessive hours. I will not allow it to interfere with my patient care nor will it be so excessive that I am too tired to learn and/or to perform the requirements of the residency. The combined hours of my residency and moonlighting will not exceed 80 hours per week, and I will not moonlight more than one shift per week.
- I understand that I may not moonlight while on call duty or during normal duty hours, as defined by the rotation I am on. I will not moonlight between 7:00 a.m. and 5:00 p.m., Monday through Friday (except for holidays), and I may not moonlight on the day after I am on call.
- I will arrange coverage for my continuity obstetrical patients while moonlighting.
- I agree to follow all rules and policies as established by the residency and understand that failure to do so may result in revocation of moonlighting privileges and/or other disciplinary action.

**Moonlighting Details:**

Location and Type of Practice: \_\_\_\_\_

Point of Contact (Name and Phone #): \_\_\_\_\_

Number of Hours Planning to Work Each Week: \_\_\_\_\_ Each Month: \_\_\_\_\_

\_\_\_\_\_  
Signature of Resident

\_\_\_\_\_  
Date

\_\_\_\_\_  
To be Completed by the Program Director upon Review with the Faculty Committee

The Faculty Committee and I reviewed your above request on \_\_\_\_\_.

- Your request is granted. You must follow the rules as outlined by our program and by Morehouse School of Medicine. You must submit a monthly report to me using the required form, and must notify me in advance of any changes in your moonlighting activities other than described above.
- Your request is denied for the following reason(s):

\_\_\_\_\_  
Signature of Program Director

\_\_\_\_\_  
Date

**Morehouse School of Medicine  
Morehouse School of Medicine  
Family Medicine Residency Program  
Assessment of Resident Giving Handoff**

Resident Name \_\_\_\_\_ PGY Level \_\_\_\_\_

Date \_\_\_\_\_

Format		Check One	
		Yes	No
Verbal Mnemonic	Description		
<u>S</u> ituation	Included patient's diagnosis, current treatment, and current complaints		
<u>B</u> ackground	Vital signs, code status, medication list, pertinent labs		
<u>A</u> ssessment	Synthesis of current status, anticipation of changes		
<u>R</u> ecommendation	Clear indication of tests/labs/consults to follow up. To-do list for next shift/overnight. Recommendation for future care		

<b>Quality Markers</b>	<b>Yes</b>	<b>No</b>
Actively engages receiver to ensure shared understanding of the patient (Encouraged questions, asked questions, etc.)		
Appropriately prioritizes key information, concerns, or actions		
Were if/then scenarios used in the to-do list?		
To-do list limited to items that should be accomplished in next shift/overnight		
Any miscommunications or transfer of erroneous information?		
Any omissions of important information?		
Any tangential or unrelated information?		

**Morehouse School of Medicine  
Family Medicine Residency Program  
Promotion Criteria PGY-1 to PGY-2 Form**

Promotion Criteria from PGY-1 to PGY-2

Following at least twelve (12) months of training, the Residency Advisory Committee will make a recommendation for promotion to PGY-2 status based on the following criteria:

Patient Care

Regarding patient care, the intern will:

- Role-model competent whole person care to other residents and medical students.
- Have documented participation in at least 20 deliveries prior to assuming continuity maternity patient coverage OR participate in an active plan to ensure adequate total deliveries (such as an elective in OB).
- Demonstrate the ability to independently perform a complete history and physical exam, write appropriate orders, and appropriately document the hospital course for inpatients.



- Have demonstrated competency in basic procedures to include Pap smears, I&D, suturing, and wet preps as confirmed by clinical preceptors.

### Medical Knowledge

Regarding medical knowledge, the intern will:

- Satisfactorily pass all required rotations.
- Have achieved at least 10th percentile on the composite score of the Family Medicine In-Training Exam or demonstrated equivalent level performance on a program-administered reassessment.
- Have achieved a minimum of the level 2 milestone on the MK-1 and MK-2 subcompetencies.
- Have taken the USMLE Step III examination by the last day of the 12<sup>th</sup> month of training.

### Practice-Based Learning and Improvement

Regarding practice-based learning and improvement, the intern will:

- Demonstrate the ability to give and receive feedback and make improvements in his/her patient care.
- Demonstrate an ability to assimilate and apply medical information to patient care.
- Participate in forums that discuss and improve systems for medical education, patient care, or resident well-being.

### Interpersonal and Communication Skills

Regarding interpersonal and communication skills, the intern will:

- Demonstrate the ability to communicate respectfully and effectively with patients, faculty, staff, and colleagues in a manner that will be conducive to assuming a supervisory role by October of the second year.
- Demonstrate adequate documentation skills to include checkouts, on- and off-service notes, and outpatient charting.

### Professionalism

Regarding professionalism, the intern will:

- Have demonstrated adequate participation in academic and professional activities such as conferences, rounds, and meetings, and pursuit of certification exam completion.
- Model professional behavior to students in clinic and rotations.
- Have achieved at least the minimum required conference attendance of 75%.

- Demonstrate adherence to policies regarding procedural documentation.

Systems-Based Practice

Regarding systems-based practice, the intern will:

- Demonstrate ability to coordinate care with case managers and other resources.
- Demonstrate cooperation within the medical system to ensure excellent patient care as seen by timely completion of medical records, charting, and follow-up.

**Comments:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

We, as members of the faculty of Morehouse School of Medicine Family Medicine Residency, verify the accuracy of the above information and believe that this Intern HAS/HAS NOT demonstrated sufficient professional ability to be promoted to PGY-2.

\_\_\_\_\_  
Program Director

\_\_\_\_\_  
Faculty Advisor

I have reviewed this document and understand that it is the basis for either my promotion or remediation plan. In addition, I have read and am in understanding of the expected PGY Level Responsibilities and Duties as found in the Family Medicine Program Manual.

\_\_\_\_\_  
Resident

\_\_\_\_\_  
Date

**Morehouse School of Medicine  
Family Medicine Residency Program  
Acknowledgement of Promotion and PGY-3 Duties**

**PROMOTION CRITERIA FROM PGY-2 TO PGY-3**

Patient Care

Regarding patient care, the resident will:

- Be a role-model of competent and compassionate whole person care to junior residents and medical students.
- Have documented participation in adequate continuity deliveries to assure a total of 20 by graduation OR will participate in a plan to achieve this goal.
- Demonstrate the ability to supervise a complete history and physical exam and oversee appropriate orders for hospital care.

- Assume an active role in diagnosis and treatment plans which is based on sound medical knowledge.
- Have documented adequate procedural competency to supervise the in-patient team adequately, including competency on knowledge and skill domains on EKG interpretation, ICU management, code management, etc.

Medical Knowledge

Regarding medical knowledge, the resident will:

- Satisfactorily pass all required rotations. Evaluations from each rotation must be received. A verbal report from the preceptor of his or her intent to give a passing grade may be taken for the final rotation of the year, if the committee meets prior to the completion of that rotation.
- Have achieved at least 25<sup>th</sup> percentile on the composite score of the Family Medicine In-Training Exam OR be participating in a program for academic enhancement.
- Have passed USLME Step 3 by his or her 20<sup>th</sup> month of training.

Practice-Based Learning and Improvement

Regarding practice-based learning and improvement, the resident will:

- Demonstrate the ability to give and receive feedback and make improvements in their patient care and practice.
- Demonstrate an ability to independently locate, assimilate, and apply medical information to patient care.
- Participate in forums that discuss and improve systems for medical education, patient care, or resident well-being.

Interpersonal and Communication Skills

Regarding interpersonal and communication skills, the resident will:

- Have the ability to role-model respectful and effective communication with patients, faculty, staff, and colleagues.
- Facilitate continuity of care through communication and documentation skills such as patient handoffs, on- and off-service notes, and telephone/message documentation.

Demonstrate teaching and management skills to effectively coordinate the teaching service and to teach junior residents and student learners

**Comments:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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We, as members of the faculty of Morehouse School of Medicine Family Medicine Residency, verify the accuracy of the above information and believe that this Intern HAS/HAS NOT demonstrated sufficient professional ability to be promoted to PGY-3.

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Program Director

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Faculty Advisor

I have reviewed this document and understand that it is the basis for either my promotion or remediation plan. In addition, I have read and am in understanding of the expected PGY Level Responsibilities and Duties as found in the Family Medicine Program Manual.

---

Resident

---

Date

**Morehouse School of Medicine  
Clinical Competency Committee  
Policies and Responsibilities**

**Purpose**

The Clinical Competency Committee (CCC) for the Morehouse School of Medicine Residency Program is charged with monitoring resident performance and making appropriate recommendations to the program director regarding each resident's progression and promotion. At all times, the policies and procedures of the CCC will comply with those of the Morehouse School of Medicine (MSM) Graduate Medical Education (GME) regarding promotion and dismissal.

**Committee Membership**

The program director appoints all members and the chairperson of the CCC. Members will include four to six (4-6) key faculty members involved in direct resident teaching, one of whom must be the associate or assistant program director. Additionally, the Family Medicine Residency program manager shall serve as a member. The members are appointed for one (1) year and membership may be renewed annually.

## **Meetings**

The CCC will meet four (4) times per year on the second Wednesday of the month. Standing meetings shall be held in August, November, February and May. Additionally, the committee chair may schedule ad hoc meetings at the request of the program director to address urgent matters that must be handled before the next regularly scheduled meeting.

Reasons for ad hoc meetings may include but are not limited to consistently low performance or unsatisfactory evaluation scores of a resident; consistent lack of adherence to program requirements; or a specific incident that requires CCC review for possible probation or dismissal.

## **Committee Responsibilities**

Members of the Family Medicine Clinical Competency Committee will:

- Attend all standing and ad hoc CCC meetings.
- Sign the confidentiality policy prior to the first CCC meeting of each academic year and must abide by said policy at all times.
- Review the following documentation of resident performance at each standing meeting: evaluations by all evaluators, In-Training Exam scores, OSCE performance, research progress, advisor documentation, program director documentation, procedure logs, teaching activity, and record of remediation where applicable.
- Make recommendations to the program director and associate program director (APD) for resident progress including promotion, remediation, and dismissal, in accordance with GME policies as outlined in the MSM GME Policy Manual.

The committee chairperson will:

- Comply with all responsibilities described above.
- Record detailed minutes of all meetings and disseminate the minutes to all committee members, the program director and the department chairperson.
- Prepare a written recommendation of progression, promotion or adverse action to the program director.
- Prepare and submit the required semi-annual summative report of each resident's performance for each Milestone to the ACGME and the Family Medicine Residency program director.

The Family Medicine Residency program manager will maintain a file of all CCC reports and recommendations for each resident.

## **Resident Review**

The CCC shall evaluate the residents on a quarterly basis in order to produce a consensus recommendation on each resident. In reviewing each resident, the CCC shall consider the following evaluation tools:

- Rotation evaluations
- 360 evaluations (including peer, self, clinical staff)
- In-Training Exam scores
- OSCE performance reports
- Research progress
- Advisor documentation
- Program director documentation
- Procedure logs
- Noon conference attendance
- Teaching activity
- Any reports of unprofessional behavior as submitted by the program director, faculty or peers
- Record of remediation, where applicable

The CCC can set thresholds for remediation, probation, and dismissal based on these evaluation measures.

## **Recommendations**

Based on the comprehensive review of each resident's record of performance, in the case of inadequate performance, the CCC may recommend probation with remediation or delay or deny promotion or board recommendation as appropriate for the deficiencies identified. In accordance with MSM's "Resident Promotion Policy" and "Adverse Academic Decisions and Due Process Policy, the CCC may make the following recommendations to the PD and APD:

- **Progression**—Resident is performing appropriately at current level of training with no need for remediation.

Resident should continue with the current curriculum.

- **Promotion**—Resident has demonstrated performance appropriate to move to the next level of training without the need for remediation.

Resident should progress with next PGY level as scheduled.

- **Notice of Deficiency**—Resident has demonstrated performance below the expected level in a specific competency across multiple evaluations, but does not require remediation.
  - The resident must submit a corrective action plan to eliminate the deficiency.
  - The CCC will prepare a statement for the grounds for Notice of Deficiency, including identified deficiencies or problem behavior.
  - Notice of Deficiency may be removed from the resident file if the resident is performing at satisfactory level and deemed to have corrected his or her deficiency within a time frame defined by the CCC, not to exceed six (6) months.
  
- **Notice of Deficiency with Remediation**—Resident has demonstrated performance below the expected level in a specific competency and requires remediation.
  - Notice of Deficiency **REQUIRES** the resident (in conjunction with the PD and advisor) to develop a **REMEDICATION** plan to cure the deficiency.
  - The CCC will prepare a statement for the grounds for Notice of Deficiency and Remediation, including identified deficiencies or problem behaviors.
  - The CCC must review the resident’s performance every three (3) months to determine if the resident is meeting the terms of the remediation plan.
  - Remediation (total time) shall not exceed six (6) months in an academic year.
  - This recommendation remains on the resident’s permanent record.
  - Failure to successfully remediate and cure the deficiency could result in extended remediation, additional training time, non-renewal, or dismissal from the program.
  
- **Immediate Suspension**—Resident has performed serious misconduct or has posed a threat to colleagues, faculty, staff, or patients.
  - This may result from gross unprofessional or unethical behavior, misconduct, or the serious threat to the safety of patients such that continuation of clinical activities by the resident is deemed potentially detrimental or compromising to patient safety or the quality of patient care, or threatening to the well-being of staff or the resident.
  - The CCC will prepare a statement for the grounds for suspension, including the identified deficiencies or problem behaviors.
  - Suspension shall not exceed 30 days. The CCC must conduct a review in 30 days if additional time is recommended.
  - This recommendation remains on the resident’s permanent record.



- **Probation**—Resident has demonstrated challenges in specific competencies that are disruptive to the program.
  - This may result when, after documented counseling, a resident continues not to perform at an inadequate level of competence; demonstrates unprofessional or unethical behavior; engages in misconduct that could bring harm to patients, negatively impact the function of the healthcare team, or cause residency program dysfunction; or otherwise fails to fulfill the responsibilities of the program.
  - The CCC will prepare a statement for the grounds for probation, including identified deficiencies or problem behaviors.
  - Probation (total time) shall not exceed six (6) months in a calendar year.
  - This recommendation remains in the permanent record.
  
- **Non-Promotion**—Resident will not be promoted to the next year of training due to repeated performance/academic deficiencies. Resident’s current level of training will be extended. Action remains in permanent record.
  - Based on repeated demonstration of deficiency(ies), the resident will not be promoted to the next level of training.
  - The CCC will prepare a statement for the grounds for non-promotion, including identified deficiencies or problem behaviors.
  - The resident’s current level of training will be extended as recommended by the CCC.
  - The resident’s contract shall be renewed for the next academic year.
  - This recommendation remains in the permanent record.
  
- **Non-Renewal**—Resident will not be promoted to the next year of training due to repeated performance/academic deficiencies.
  - Based on repeated demonstration of deficiency(ies) the resident will not be promoted to the next level of training.
  - The CCC will prepare a statement for the grounds for non-renewal, including identified deficiencies or problem behaviors.
  - The resident’s contract shall expire at the end of the academic year, without renewal.
  - This decision may be appealed by the resident in accordance to GME policies of Due Process (“Adverse Academic Decisions and Due Process Policy”).

- This recommendation remains on the resident’s permanent record.
- **Dismissal**—Resident will not be promoted to the next year of training due to repeated performance/academic deficiencies; the resident will be dismissed from the program. Action remains in permanent record.
  - Based on repeated demonstration of deficiency(ies) the resident will be immediately dismissed from the program.
  - The CCC will prepare a statement for the grounds for dismissal, including identified deficiencies or problem behaviors.
  - The decision may be appealed by the resident in accordance to GME policies of due process (“Adverse Academic Decisions and Due Process Policy”).
  - This recommendation remains on the resident’s permanent record.

The CCC consensus recommendation for each resident will be submitted to the residency program director using the Clinical Competency Committee Report Form as completed by the CCC chair. All residents who receive an adverse recommendation shall also receive written notice of the CCC recommendation of adverse action form. The program director shall review all recommendations, and the PD and APD will meet with each resident to communicate his or her recommendation. A copy of all adverse decisions shall also be sent to the affected resident’s advisor for review. The advisor will then work in concert with the program director and resident to develop the remediation plan.

## **Faculty Development**

In order to ensure the greatest usefulness of the data reviewed by the CCC, the CCC will conduct, with the assistance of the Morehouse School of Medicine Office of Graduate Medical Education; two faculty development sessions will be held annually. One will cover completing resident evaluations and the other will cover the Family Medicine residency milestones.

Prior to each evaluation session, a faculty committee meets to discuss the resident's performance and to arrive at the summary with specific recommendations. The results of the faculty appraisal are shared with each resident individually by the resident faculty advisor. The resident is asked to sign the summary form to acknowledge discussion of the evaluation. Information used in assessment of resident performance is derived from multiple sources, which may include:

- If any time, at or between the formal six-month evaluations a problem is identified with any portion of the resident's performance and educational growth, this information will be shared promptly with the resident. The information will be documented. If there is a deficiency that the faculty or the program director decides requires further action, a future meeting will be arranged with the appropriate faculty members and the resident to devise a plan of corrective action. Such plans will contain measurable goals and a specific timeframe for re-evaluation.
- If the resident fails to show progress in correcting the deficiencies or fails to adhere to the plan of corrective actions, further recommendations, including possible probation or dismissal from the program, may ensue. Any time formal discipline is invoked, the resident has the right to due process, as outlined in the Morehouse School of Medicine Graduate Medical Education Policies and Procedures.

**Morehouse School of Medicine  
Family Medicine Residency Program  
Program Evaluation Committee  
Policies and Procedures**

The ACGME requires that the program is evaluated and that the program director appoint a Program Evaluation Committee (PEC) to assist in reviewing the program on an annual basis.

The following roles and responsibilities apply to the MSM Family Medicine Program Evaluation Committee (PEC):

- The purpose of the Program Evaluation Committee (PEC) for the Morehouse School of Medicine (MSM) Family Medicine Residency Program is to oversee and participate actively in all aspects of the program quality and improvement process.
- At all times, the procedures and policies of the PEC will comply with those of the Graduate Medical Education Committee as outlined in the Graduate Medical Education Policy and Procedure Manual and with those stipulated by the Accreditation Council for Graduate Medical Education (ACGME) as outlined in the ACGME Program Requirements for Graduate Medical Education in Family Medicine.

**Membership**

The program director shall appoint and the department chairperson shall approve all members of the PEC, including the committee chairperson. The committee shall consist of no fewer than two (2) core program faculty members and at least one (1) resident.

**Responsibility of Members**

Committee members are expected to participate actively in the following duties in accordance with the ACGME program requirements:

- Planning, developing, implementing, and evaluating educational activities of the program
- Reviewing and making recommendations for revisions of competency-based curriculum goals and objectives
- Addressing areas of non-compliance with ACGME standards
- Reviewing the program annually using evaluations of faculty, residents, and others, as specified below:

- Document formal, systematic evaluation of the curriculum at least annually, and render a written and Annual Program Evaluation (APE) based on its review and analysis of tracking in each of the following areas:
  - Resident performance
  - Faculty development
  - Graduate performance, including performance of program graduates on the certification examination
  - Program quality
  - Progress on the previous year's action plan(s)
- Prepare a written plan of action to document initiatives to improve performance in one or more of the areas listed above, as well as delineate how they will be measured and monitored (per Section V.C.3 of the ACGME Program Requirements for Graduate Medical Education in Family Medicine); and attain approval of the action plan by the teaching faculty.
- Review and address deficiencies in the following ACGME program requirements.
  - At least 95 percent of the program's eligible graduates from the preceding five (5) years must have taken the American Board of Family Medicine (ABFM) certifying examination.
  - At least 90 percent of the program's graduates from the preceding five (5) years who take the ABFM certifying examination for the first time must pass.
  - Every five-year survey of program graduates.
  - Assessment of resident attrition and the presence of a critical mass of residents with a goal of no more than 15%.

## **Meetings**

- Scheduled Meetings

The PEC will meet a minimum of four times per year. The PEC, in entirety or in subcommittees, will meet at least annually to document the systematic and formal evaluation of the curriculum and produce a written APE.

- Ad Hoc Meetings

The program director or committee chairperson may request an ad hoc meeting of the PEC or subcommittee to address urgent resident performance issues and those who are engaged in the grievance process for an adverse academic decision. At all times, the committee will adhere to the GME policies and procedures of the “Adverse Academic Decisions and Due Process Policy.”

### **Procedure**

The PEC shall evaluate the program on an ongoing basis and make recommendations to the program. All PEC meetings shall be documented with agendas and meeting minutes as appropriate.